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ABSTRACT

This report summarizes the conference proceedings of the fourth Head Start National Research Conference. The focus of the conference was on creating a shared agenda for researchers, practitioners, and policy makers related to serving children and families in an era of rapid change. Keynote topics and speakers are: "Countering the Health Effects of Poverty on Children and Families" (Norman Anderson); "Researchers, Practitioners, and Policy Makers: Hanging Together or Hanging Separately" (Jack P. Shonkoff); and "An Embarrassment of Riches: Partnering for High Quality Research and Programs During Head Start Expansion" (Eleanor E. Maccoby). Other special session topics included the effects of immigration and migration of children and their communities and early childhood assessment. Thirty-seven symposia are summarized in the areas of: (1) Head Start research and practice; (2) Administration of Children, Youth, and Families research; (3) cultural diversity; (4) family support and parenting; (5) health, mental health, and resiliency; (6) language development and school readiness; (7) research methods, measures, and assessment; (8) researcher-practitioner partnerships and collaborations; and (9) miscellaneous. Poster sessions are also summarized on the following topics: (1) children and technology; (2) classroom environment; (3) cultural and linguistic diversity; (4) curriculum development; (5) early education; (6) exceptional children; (7) fathers; (8) health; (9) infants and toddlers; (10) measurement techniques; (11) mental health; (12) research methods; (13) normative child development; (14) parenting; (15) parent education; (16) parent involvement; (17) school

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readiness; (18) staff development; (19) teacher-child interaction; (20) transition; and (21) welfare reform. Four appendices include a list of the cooperating organizations and peer reviewers, a subject index, and a directory of participants. (KB)

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ED 429 700

SUMMARY OF CONFERENCE PROCEEDINGS

CHILDREN AND FAMILIES IN AN ERA OF RAPID CHANGE

Creating a Shared Agenda for Researchers, Practitioners and Policy Makers

Head Start's Fourth National Research Conference

July 9–12, 1998
Washington, D.C.

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Presented by
Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services

In collaboration with
Columbia University's
Joseph L. Mailman School of Public Health
Center for Population and Family Health

and
Society for Research in Child Development

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Columbia University's
Joseph L. Mailman School of Public Health
Center for Population and Family Health
60 Haven Avenue, B3
New York, NY 10032

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in collaboration with
Society for Research in Child Development
University of Michigan
505 E. Huron, Suite 301
Ann Arbor, MI 48104-1522

for the
Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services

Project Officer:
Esther Kresh
Administration on Children, Youth and Families
Head Start Bureau

Editors:
Faith Lamb-Parker
John Hagen
Ruth Robinson
Cheryl Clark

Editorial Assistants:
Debra A. Jones
Nicole Ives
Ronna Montgomery
Abbie Raikes
Jennifer Maahs
Catherine Wright
Amy Knight
Rachel Sturke

Layout and Design:
Valerie Collins
Michele Phillips

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Special Sessions

Opening Session

KEYNOTE SPEAKER:

Norman B. Anderson
Director, Office of Behavioral and Social Sciences Research
National Institute of Health

Countering the Health Effects of Poverty on Children and Families: Successes and Challenges in Prevention Research

Norman B. Anderson is the first Associate Director of the National Institutes of Health for Behavioral and Social Sciences Research. As Director of the Office of Behavioral and Social Sciences Research, he is charged with facilitating behavioral and social sciences research across all of the 24 Institutes, Centers, and Divisions that comprise the National Institutes of Health.

Dr. Anderson is Associate Professor in the Departments of Psychiatry and Psychology: Social and Health Sciences, at Duke University. He is also Director of Duke's Program on Health, Behavior and Aging in Black Americans and was Director of the Exploratory Center for Research on Health Promotion in Older Minorities.

The problems of high blood pressure in African Americans is Dr. Anderson's primary research interest. His special focus is in trying to understand how social, psychological, behavioral, and biological factors affect blood pressure. For this research, he has received several awards including: (1) the 1986 New Investigator Award form the Society of Behavioral Medicine; (2) the 1991 Award for Outstanding Contributions to Health Psychology from the American Psychological Association; and (3) a Research Scientist Development Award from the National Institute of Mental Health and several other awards from scientific societies. His research has been funded by three different institutes of the National Institutes of Health.

Dr. Anderson is a Fellow of the American Psychological Association, the Society of Behavioral Medicine, and the Academy of Behavioral Medicine Research. He is President-Elect of the Society of Behavioral Medicine. He has served on the editorial boards of several journals including Health Psychology and the Journal of Gerontology: Psychological Sciences, and was an Associate Editor for Ethnicity & Disease.

Faith Lamb-Parker: Welcome to Head Start's Fourth National Research Conference. I bring greetings from Alan Rosenfield, Dean of the Columbia University's Joseph L. Mailman School of Public Health. Our collaborating organization is the Society for Research in Child Development; John Hagen, SRCD's Executive Officer and I have been partners in this endeavor since 1990. We have seen the birth and growth of these research conferences and take great pride and pleasure in being part of what can be tangibly seen as the ongoing development of strong and sustained partnerships between researchers and practitioners, especially those in the Head Start community.

I also bring you sad news. Esther Kresh, our colleague, friend, and Federal Project Officer will not be attending the conference due to illness. It was Esther who conceptualized a research

conference where practitioners and researchers would be able to come together and learn from each other. John, the program committee, and I have greatly appreciated her dedication to the projects and her keen intelligence and creativity in developing outstanding programming. We will miss her very much this week.

The program committee has worked long and hard to develop this program. The committee members are:

Anne Bardwell, Child Development Council of Franklin County, Ohio;
Kathryn Barnard, University of Washington;
Willie James Epps, Southern Illinois University;
Sarah M. Greene, CEO of the National Head Start Association;
Aquiles Iglesias, Temple University;
Gloria Johnson-Powell, Harvard Medical School;
Mireille Kanda, the Administration on Children, Youth, and Families;
John "Jack" Pascoe, University of Wisconsin, Madison;
Lonnie Sherrod, William T. Grant Foundation;
Mary Bruce Webb, Administration on Children, Youth and Families;
Edward Zigler, Yale University and his assistant *Jean Turner;*
Esther Kresh; John Hagen; and *myself.*

The number of cooperating organizations for the conference has grown considerably since the first conference where just 20 national membership organizations were on our list. We now have 65 organizations representing both research and practice, and covering a wide range of disciplines. I would like to thank these diverse organizations that have given freely of their expertise and time in program development and have spread the word about this unique conference.

I also would like to thank the program staff from Columbia: Ruth Robinson, Senior Project Associate, and Debra Jones, Graduate Research Assistant, for their hard work and consistent good humor in the face of inevitable crises. I would also like to thank Abbie Raikes and Katherine Rogers at Columbia, who often helped us when things got really hectic; Lynne Erler and the staff of Dakota Technologies for their conference support; and Cheryl Clark, consultant from Ellsworth Associates for coordinating that support and being an all-around great person to work with. I now turn the podium over to John Hagen.

John Hagen: On behalf of the Society for Research in Child Development, I want to convey my thanks to all the people from the Head Start community who have been working with us for the last 8 years. It is difficult to believe that this is Conference IV and Faith and I have actually been involved in all of them.

Our multiple goals of involving people in Head Start more actively in research, and at the same time, having people from the research community in child development become more actively involved in Head Start, have continually been achieved and each conference brings more evidence to the fore. With each of the meetings, we have had more and more SRCD members involved as well, and I see that two past presidents of SRCD, Eleanor Maccoby and Bob Emde, are seated right in the front row. I think that also attests to the success of these conferences.

Helen Taylor, Associate Commissioner, Administration on Children, Youth and Families, Head Start Bureau, will now make some comments and introduce our keynote speaker.

Helen Taylor: I am delighted to be here. I missed our third National Research Conference because I was ill at the time. I did have the opportunity to participate in the first two conferences, and I am so delighted that I can be here at the fourth. Our theme, "children and families in an era of rapid change," is very appropriate.

I want to thank Faith Lamb-Parker and John Hagen, along with the other members of the

program committee for putting together such a wonderful and exciting program. We have some stars in our field addressing us in our plenaries and luncheons and it promises to be a stimulating and wonderful conference. I too want to thank all the cooperating organizations that worked with the committee and bureau in making this event happen. I also bring you greetings from Esther Kresh. This conference is her baby and she is very sad about not being here, but her thoughts and her heart are here with you. We have cards available to send to Esther. So please write her a note or sign a card and we will deliver them to her daily.

As the largest national child development program for children from birth to 5 and their families, a major part of Head Start's mission is to serve as a national laboratory, to test new ideas, and to contribute new knowledge about how to best serve low-income families and their children. With its diverse population and local responsiveness to programming that best serves the needs of each community, Head Start provides a unique opportunity for partnerships among researchers, Head Start staff, and parents.

When I came to this job, Ed Zigler told me that the most important thing I had to remember was that what made Head Start different was its role as a national laboratory and to push to do new things. We try to do that and will continue to work on being innovative.

This is the fourth National Research Conference sponsored by the Head Start Bureau. There are several goals of these conferences: (a) to bring the most recent and best research in early childhood development, child care, and family issues to the early intervention community; (b) to provide a forum for practitioners to share their expertise and issues they are facing in the field with the research community in order to help them form the most relevant research questions; and (c) to build strong, enduring partnerships among researchers, practitioners, and policy makers concerned with low-income children and their families.

I have watched the development and growth of these conferences as they have become increasingly proactive, dynamic, and responsive to the needs of both practitioners and researchers. I have seen partnerships develop where there were none. I have seen Head Start directors embrace researchers' efforts and work wholeheartedly together toward a common goal where before there was suspicion of the researchers' intentions. I have seen researchers pitch in to help cook meals at Head Start programs while conducting their research, whereas in the past they would have kept at arm's distance to "remain objective" while collecting their data. Now we have found the balance that we need in order to provide the answers to the important questions about children and families.

The Bureau recognizes the importance of partnerships in research exemplified by our recent initiatives: Head Start/University Partnerships, the Early Head Start local research, and the Quality Research Centers. It is in these and other projects that the process of partnership grows and develops.

Head Start is currently undergoing reauthorization, and on June 22nd the Senate wrote a bipartisan Head Start bill reauthorizing the program for the next 5 years. Some of the key themes of this bill included a focus on school readiness as a major purpose of Head Start, expanding our Early Head Start effort from 5% to 10% of Head Start programs, and a major focus on research. As part of that effort, the Senate directs us to call together an expert research panel to advise Head Start about research as we move into the 21st century.

I want to give a charge to all of you. For the researchers, I ask you to continue to do the best research possible, because there are many questions we need to answer in our field. Practitioners, I charge you to continue to feed research your most pressing problems and to keep telling researchers what it is like in the field. Most importantly, to both practitioners and researchers—I want you to continue to create and build new and enduring partnerships by learning each other's language, formulating mutual goals, and, most of all, listening to each other as we move forward, increasing our knowledge base about young children and their families.

It gives me great pleasure to introduce our Keynote Speaker, Norman Anderson. As director of the Office of Behavioral and Social Sciences Research at the National Institutes of Health, he

facilitates behavioral and social science research across all 24 institutes, centers, and divisions that comprise the National Institutes of Health.

Norman Anderson is Associate Professor in the Departments of Psychiatry and Psychology: Social and Health Sciences, at Duke University. He is also director of Duke's Program on Health, Behavior, and Aging in Black Americans and was the director of the Exploratory Center for Research on Health Promotion in Older Minorities. His primary research interest, for which he has received several awards, is the problem of high blood pressure in African Americans, with a special focus on trying to understand how social, psychological, behavioral, and biological factors affect blood pressure.

Dr. Anderson is a fellow of the American Psychological Association, the Society of Behavioral Medicine, and the Academy of Behavioral Medicine Research. He is President-Elect of the Society of Behavioral Medicine. He has served on the editorial boards of several journals including *Health Psychology* and the *Journal of Gerontology: Psychological Sciences* and was an Associate Editor for *Ethnicity and Disease*.

Norman Anderson: Being invited to speak here has given me the opportunity to learn a lot about the Head Start Program and, in fact, I have come to realize that Head Start represents the best example of the collaboration between science, practice, and the community.

Most of you know about the Office of Behavioral and Social Sciences Research at NIH that I direct. The office was created by Congress to increase the focus and emphasis on behavioral and social sciences research across all of the institutes of NIH. As Dr. Taylor said, the NIH is composed of 24 institutes and centers, such as the National Cancer Institute, the National Institute of Mental Health, and the National Heart, Lung, and Blood Institute.

Behavioral science is very broad and includes such diverse subjects as research on learning and memory to interventions in entire communities. What I am especially excited about right now are the success stories in the area of prevention research. I think this area of research will be of great interest to Head Start practitioners and researchers. At the same time, Head Start has a great deal to offer researchers in the area of prevention.

I will talk about countering the effects of poverty on children, youth, and families and the successes and challenges in prevention research. In addition, I will discuss the devastating health effects of poverty; why a person's income or education level translates into diseases such as cancer and heart disease, some of our success stories in preventing these health effects of poverty, and the biggest challenges for prevention science.

I certainly do not have to talk to this audience about the extent of poverty in this country and its health effects. Recently, a *New York Times* article discussed how the youngest children in the United States are the poorest, and that while the number of American children living in poverty has actually declined since 1993, children younger than age 6 remain the poorest group in the nation.

I want to share some historic and more recent research on the effects of poverty on health. An article published in the *American Journal of Public Health* in 1924 reported on death rates among taxpayers and nontaxpayers in Providence, Rhode Island, during 1865. They found that when they looked at deaths per 1,000, the death rate of nontaxpayers was over twice the death rate of taxpayers. What one has to remember is that in 1865, it was the taxpayers who were the affluent members of society.

In a cemetery outside of the Cathedral Necropolis in Glasgow, Scotland, there are grave markers in many different shapes and sizes, but the one dominant shape is an obelisk. Some very enterprising researchers from Great Britain wondered if the height of these markers had anything to do with how long the person under those markers had lived. The rationale was very creative: They thought that if a family's income related to death, then all richer families could afford taller markers. Obviously the taller the marker, the more expensive the marker. They reasoned that if one came from a more affluent family one's life span would have been longer. I

suppose they got their graduate students to measure the height of the markers and then record the length of the person's life span. They found that people with taller markers lived longer. It was a very statistically significant finding, and if there are interested students in the audience, this has never been replicated.

More modern research investigates socioeconomic status (SES) by looking at 1 of 3 measures: highest educational attainment, income, or certain measures of status of one's occupation. Generally speaking, as one moves up the SES ladder, regardless of which of these measures one uses, morbidity, death, and illness go down. What is interesting about the SES gradient is that it seems to extend even into the upper reaches of one's status. For example, a person who earns $500,000 a year seems to have a better health risk profile than someone who earns $250,000 a year—both by any measure are affluent, but the more affluent one is, the better one's health profile. When looking at limitations and physical illness among children, there is a very strong relationship between those limitations and SES. In fact, the mother's or the father's level of education does relate to illness in children.

We know that poverty is bad for your health, but it may be even worse than we ever imagined. Many health problems in adults actually have their origins in youth. A recent paper published in *Social Science and Medicine*, 1997, looked at whether illness in adults was more a function of their current level of social class or the social class of their upbringing—their parents' or guardians' social class. This was a major epidemiological study in Finland where at birth everyone is registered into an epidemiological study, so there are records on the entire population. They found that in a multivariate logistic regression analysis both past and especially present social class are important determinants of health. Current SES showed the strongest association with adult health, but living conditions during childhood, particularly economic problems and status of origin, were also significant predictors. This is one of the first well-done studies showing that where a person begins life in terms of social class not only relates to their current health, but also to their health years later. When we try to determine why there are so many chronic diseases, we cannot just focus on contemporary factors, but also on factors that could have origins in childhood. We need to ask two questions: How is it that one's educational attainment or one's parents' educational attainment translates into all of these diseases? What are the mechanisms responsible for this?

Another factor seldom addressed is family wealth. It is a particularly important measure when we try to understand why African American and White people of the same social class, using the measure of highest educational level attained, have different health outcomes. The differences in family wealth, which many epidemiologists fail to take into account, might be the answer. We need to think about social, environmental, and medical factors such as neighborhood characteristics, psychological factors like stress, and health promoting versus health damaging behaviors. Then, of course, this information needs to be put through a biological process because many of the disorders mentioned are measured biologically.

Even though researchers have done a great deal of work looking at the ways SES might affect health, we still do not have the answers. The puzzle of SES and health remains unsolved. There must be factors that have yet to be discovered or measured properly, which account for this relationship.

An additional issue is how to counter some of these health effects in children and families. Let me first ask why should Head Start researchers, practitioners, and administrators be interested in health-related prevention? There are a number of reasons why they should be interested. First, as a prevention program designed to counter the cognitive, intellectual, socioemotional, and physical effects of poverty on children, Head Start has, in fact, been interested in health. Recent studies suggest that Head Start children, when compared to children who were not in Head Start, are more likely to have improved health, better access to health care, receive basic health services, eat meals of higher nutritional quality, exhibit better motor coordination, and are more likely to have been immunized.

However, I would like to reverse that question and ask why should health-oriented prevention researchers be interested in Head Start? The answer is that in many respects Head Start provides the ideal structure and opportunity to examine the impact of early preventive interventions with children and families living in poverty. Prevention research does indicate that the earlier one begins preventive interventions, the better the outcomes. It is my hope that eventually behavior-oriented and community-oriented disease prevention efforts with families will become a key feature of Head Start. For this to happen, researchers must provide the types of data that would prove useful in the context of Head Start programs. I am sure some of this work has already begun.

What do American adults believe is the most serious problem facing children? The answer is drugs. This has surprised many people, but in a recent report on a study that asked about their chief worries and what they felt were the most serious problems facing children, adults answered overwhelmingly, "drugs." Crime and the breakdown of home life rank a distant second and third respectively. Concern about health care and the ability to pay for it was hardly mentioned. Injuries, the leading cause of death among children, did not even make the list, nor did smoking, the leading cause of preventable illness in adults. AIDS was the only disease mentioned by at least 1% of adults responding.

When it comes to prevention, we must recognize the connection between drug abuse and the use of other substances. Drug abuse is not an isolated behavior. It occurs in a context of other health risk behaviors. A person who has smoked and/or drank is 65 times more likely to go on to use marijuana than a person who never smoked or used alcohol. A one-time marijuana user is 104 times more likely to use cocaine than someone who never used marijuana. This has been discussed for a number of years, but now science clearly shows that there is a systematic process leading to drug abuse. Someone who abuses illegal drugs is almost always also a smoker and/or someone who uses alcohol. In addition, the pattern of use occurs in a sequence.

In the case of cigarette smoking, a number of published articles have asked the question, "Is anyone getting the picture?" Despite numerous ads, teenage smoking remains unabated and the number continues to rise. Officials seek a path to cut into the haze of youth smoking, but the bottom line is that no one knows what works.

A recent *Washington Post Magazine* story discussing the problem of underage drinking reported that parents who imagine their children sip a beer or two to relax at a party have the wrong picture. Drinking is not part of the party—it is the party. Asked how often she drinks, a quiet strawberry blonde in 9th grade answers, "Whenever possible." When asked, "Was last weekend the first time you passed out?" she responds, "Well, no." Parents are ambivalent because alcohol is a legal drug. Many parents use alcohol, so there is some cognitive dissonance between talking to their children about using alcohol.

In fact, early drinking is said to increase risk of alcoholism. Nearly half the children who start drinking at age 13, face dependency problems as adults. Children who begin drinking regularly by age 13 are more than four times as likely to become alcoholics as those who delay drinking alcohol until age 21 or older. This information comes from a study by one of the institutes of NIH—the National Institute on Alcohol Abuse and Alcoholism. The findings were drawn from a study of 28,000 people and are the first to show a powerful link between age at drinking onset and a lifetime risk of alcoholism. Public health officials say that the results highlighted the importance of preventing underage drinking and delaying the use of alcohol for as long as possible.

The headlines cry out for prevention, for some solutions from the behavioral science community to address these problems, but there are some prevention success stories in the area of alcohol use. *The Journal of the American Medical Association* published a study by Gilbert Botvin and his colleagues. This work is very well known and looks at a randomized trial of drug abuse prevention programs. The purpose of the study was to evaluate the long-term (6 years) effectiveness of alcohol and drug abuse prevention programs. The study was a randomized trial con-

ducted in 56 schools in upstate New York, using four different prevention approaches. One used teachers who had received a prevention training program in a 1-day workshop and also given feedback on the implementation of the program. Another group of teachers was just given a videotape and did not go to a special class, nor were they given feedback. They were told to watch the videotape and then implement the program. Finally, there was a "no treatment" group.

The most intensive part of the intervention focused on 6th grade students who received cognitive behavioral skill training and a number of different interventions. In 7th grade, the focus was more on the immediate negative consequences of drug abuse. In 8th grade, students received "booster" sessions. In prevention research, we are finding that this is very important. One cannot just implement a program on a one-time basis; teachers need additional sessions to reinforce what they have learned. In 9th grade, and again in 12th grade, there were further booster sessions.

The findings indicate that there was no difference between those classrooms where the teachers received formal training and feedback and those who received only video training with no feedback. In all cases, there was a significant reduction in monthly and weekly smoking, reduced drinking, especially getting drunk, reduced polydrug use, and reduced use of cigarettes, alcohol, and marijuana.

The results were greatest for what they called the "high-fidelity" sample. The researchers went into the classrooms from time to time in order to measure how much of the program the teachers were actually implementing. This was essential in determining whether or not the students were actually getting their treatment. The classrooms where they found the teachers were implementing the program more effectively were labeled their "high-fidelity" sample. The results were strongest for this group because obviously the students were getting more of the treatment. This study was with a predominantly White middle-class sample, but Botvin and his associates have replicated this study now with lower-income and minority samples, with very similar results.

There are many other studies exploring the effectiveness of behavior-oriented interventions for multiple drug use. The National Institute on Drug Abuse has many documents that not only summarize the research but also include studies that are actually designed to help practitioners systematically implement the interventions. Their materials are of the highest quality and are ready to be disseminated and used almost immediately.

What is one of the key predictors of infant mortality, mental retardation, cerebral palsy, vision problems, and adult hypertension?

Audience response: Prenatal care.

Anderson: Prenatal care? You are getting warm.

Edward Zigler: Birth weight.

Anderson: Guess who answered that question? The answer is preterm birth- and low-birth weight, answered by Ed Zigler. Low birth weight is associated with higher risk for infant mortality, mental retardation, and all of the other illnesses I mentioned. Low birth weight also carries a large economic burden, beginning with neonatal intensive care in the hospital and often extending well into childhood.

In 1994, the National Center for Health Statistics looked at the percentage of all births defined as healthy in several categories. They found that mothers with less than a high school education have the fewest births that can be considered healthy (49%, as opposed to 70% for mothers with high school or more). Looking at the percentage of healthy births by race, the figures are: White, Nonhispanic = 70%, Black, Nonhispanic = 50%, and Hispanic = 55%.

Looking at mothers' marital status, the numbers are: married = 72% and single = 51%. These numbers indicate that this is a very serious problem facing society and needs to be addressed.

There is a fairly famous research study conducted by Tiffany Field and her colleagues that looked at a tactile kinesthetic or massage intervention for preterm infants. This work is an offshoot of some fairly basic animal research conducted by Saul Schandberg that shows when rat mothers stimulate their young, it causes the offspring to produce enzymes and hormones, particularly a growth hormone. Field took that animal research and applied it to humans. In her first study, one of the first significant studies, her subjects were 40 preterm neonates from an intensive care unit. They were randomly assigned to a treatment or control group; each group was comprised of the same number of infants above and below cutoff points, insuring that the treatment and control groups were the same.

The intervention group received exercises—rubbing, massage, and kinesthetic activities—3 times a day for 15 minutes each session, administered by a nurse. The control group received usual care. What Field found was that the intervention group gained weight at a much faster rate. An interesting aspect of these data is that the infants who received the massage did not consume any more food than the control infants. The weight gain was not a function of more food consumption but a function of the fact the food they did eat had a greater impact on them compared to the control group.

Field has done many studies since that have shown that massage intervention reduces stress and anxiety hormones and improves the clinical course for cocaine and HIV-exposed infants, infants of depressed mothers, and children with asthma, autism, burns, cancer, and developmental delays. It also is beneficial for full-term infants who have no medical problems. Since this intervention can be delivered by grandparent volunteers or older adults who are not related to the child, it is very cost effective. In addition, there are benefits for the volunteers as well as for the infants.

True or false: American children and adults are becoming increasingly overweight, even though interest in dieting and exercise are at all-time highs.

Audience response: True.

Anderson: Yes, it is true. In fact, American adults and children are, according to *The Washington Post*, "significantly fatter in the last 2 decades despite a nationwide obsession with dieting." That should be an urgent, repeated warning from medical experts. In addition, obesity among preschool children from low-income families has been steadily rising since 1983, according to CDC researchers, and now affects 1 in 10 toddlers. The increase was observed even in infants who were less than 2 years of age. Similar increases have been noted among school-age children, adolescents, and adults. Scientists tell us that children who are overweight are more likely to be overweight as adults. Studies show that there is a need to increase physical activity and improve the diet of preschoolers, which is of great interest to Head Start.

A recently published study, the Childhood and Adolescent Trial for Cardiovascular Health (CATCH), known as the "Catch Trial," looked systematically at interventions to improve dietary patterns and physical activity in children. The Catch Trial is based on social learning theory and was conducted in a number of states using ethnically and economically diverse samples numbering over 5,000 children randomly assigned to various groups.

There were two interventions: The first focused on food service with a goal of lowering fat and sodium content in meals served at the schools, and the second focused on increasing the physical activity of the students. The first also forced the food service staff to look at changing the way in which food is prepared and presented to children in order to affect their intake of desired nutrients. The intervention extended into the classroom to include information about diet, activity, and smoking. In some schools, a family education program was added to the above interventions to see if that added any boost to the intervention. When they found that the two intervention groups had similar results, they were combined.

Compared to the control group, the intervention group showed significant decreases in fat

content in the school lunch menus and recipes. The intervention group went from 39% fat content to 32%. The control group went from 39% fat content to 36%. The treatment group was also effective in increasing moderate to vigorous physical activity, while not as successful at just increasing vigorous activity. However, moderate is fine. These results showed that the intervention was effective with the school lunch personnel and with the physical education classes.

Leonard Epstein and his associates conducted a family-based program for obese children and recently published a follow-up 10 years after the parents and children participated in the program. He was looking at the 10-year weight gain in obese children and found that the best outcome was with the intervention where both parents and children participated.

Besides childhood poverty, and perhaps infant mortality, what issue reflects most poorly on us as a society?

Are there no guesses from the audience? I personally think it is child abuse and neglect. There is a great deal of data showing how serious a problem this is. Looking at child fatalities due to maltreatment, cases of child abuse and neglect confirmed by child protective services show a 34% increase between 1985 and 1996. In a 3-year period, 78% of child fatalities were for children less than age 5. Of these, 38% were age 1, 44 % resulted from neglect, 51% from abuse, and 5% from a combination of the two.

A report from a study done in England says child abuse typically occurs behind a veil of privacy and deceit. In the current issue of the journal *Pediatrics*, British researchers part that veil just enough to present a harrowing picture. The researchers received permission from the British Child Welfare Authorities to clandestinely videotape parents visiting their children in hospitals. The videotaped parents were all suspected of abuse, and from 1986 to 1994, hidden cameras at two hospitals filmed 39 children between the ages of 2 months and 4 years alone with their parents. In all but six cases, the cameras caught either the father or mother kicking, slapping, trying to suffocate, or otherwise physically abusing his or her child. This was in the hospital, so one can imagine what happens at home. Many of the abusers adopted affectionate behaviors toward their children as soon as the nurses walked into the room. Most of these parents had a history of serious personality disorders.

An article that recently appeared in *The New York Times* reported on a survey that showed that 1 in 8 high school-age boys said they had been abused. There is a relationship between family structure and confirmed abuse and neglect. Looking at all forms of maltreatment, one sees that children with both parents in the home have a lower rate of abuse and neglect than those with single parents or those being raised by people who are not their parents. Abuse is also related to income. Looking at all maltreatment of children, for families earning under $15,000 a year, one finds the rate of maltreatment is higher compared to families with higher incomes.

The article in *Pediatrics* also reported that childhood experience of abuse and neglect is actually linked to physical health problems in adults, such as heart disease, lung disease, liver diseases, cancer, and injuries. Adults who came from families where there was abuse or violence, or a member of the family was an alcoholic, show the long-term ramifications in ways we might not have thought about, like heart disease and cancer. A recent study reported by the National Institute of Justice has shown that a very high percentage of incarcerated male felons have an early childhood history of abuse.

Can we do anything about this terrible problem? There are researchers looking into this who have experienced some successes. Again, a paper published last year in the *Journal of the American Medical Association (JAMA)* reported on the very innovative program that David Olds and his colleagues are conducting. They are looking at the effects of home visitation by nurses on child abuse and neglect, along with the life course of the mothers. They believe that one cannot just focus on teaching parents to not abuse their children; one has to give them some hope, some way of looking toward the future with some optimism. Olds' program focuses on both prevention and additional support for parents.

This was a 15-year follow-up of a randomized trial of home visitation by nurses that involved

300 mothers. About 11% were African American with at least one risk factor for abuse, such as being under the age of 19, unmarried, or categorized as having lower socioeconomic status. Some treatment groups were given sensory and developmental screenings for their children at 12 and 24 months of age. In addition to the screenings, parents were given transportation vouchers for prenatal and well-baby care up to age 2. A second group received the same screenings and transportation, but were also visited at home by nurses. A third group received the same interventions, but the nurse's visits were extended until the child was 2 years old.

During home visits, the nurses promoted: (a) health-related behaviors during pregnancy and during the child's early years, (b) appropriate care for the children, and (c) help for the mothers with their life course development, such as family planning, educational achievement, work force participation, writing a resume, interviewing for a job, or whatever additional help they needed. Results showed that those mothers who received home visits by nurses during pregnancy and during the infancy period had fewer confirmed cases of child abuse and neglect, fewer subsequent births among unmarried and lower-SES women, more time between births, fewer preterm births, less welfare use, fewer arrests among the parents, and less substance abuse. These findings were published in *JAMA* because the effects were so amazing. This program has now been replicated with a larger sample of low-income, largely African American families in Memphis, Tennessee, and the results were very similar.

What is one of the most unrecognized problems of young people? I will give you a hint—think mental health.

Audience response: Depression.

Anderson: Yes, it is depression. The National Institute of Mental Health (NIMH), part of the National Institutes of Health, estimates that 1.5 million American children under the age of 18 are seriously depressed. The American Academy of Child and Adolescent Psychiatry actually puts this number at more than twice the NIMH estimate.

Can we do anything to prevent depression in young people? Until recently, the answer was "no." We have had studies on programs to prevent the onset of mild depressive symptoms, but we did not have a well-controlled study on the prevention of clinical depression, the DSM-IV definition of diagnosable depression in children. This study focused on unipolar depression in high-risk children. The researchers screened a group of children in order to find their sample of those who were at high risk for depression. These children were already experiencing mild symptoms of depression. For the study, they arrived at a sample of about 75 each in the treatment and control groups. The intervention was called "Coping with Stress," and consisted of 15 sessions, 45 minutes each. The children were taught to identify and challenge negative and irrational thoughts. It has been shown that these negative thoughts promote certain mood disturbances. Over time, they found that depression was increasing in both groups, but the experimental group actually had the best outcomes. This group had a higher percentage of participants in whom they were able to prevent depression, while in the control group, a higher percentage developed clinical depression. This is one of the first times that a study has shown that an intervention can prevent clinical depression.

What is the leading cause of death for African Americans between the ages of 25 and 44? Most would think the answer is, "violence," but it is a trick question because of the age range. It is actually AIDS. If I asked, "between the ages of 15 and 34," the answer would be different.

A recent article in *The New York Times* states that 17 years after AIDS was first recognized among gay White men in New York and San Francisco, the disease in this country is now largely an epidemic among African Americans. This disease is quietly devastating families and neighborhoods, yet it is being all but ignored by leading African American institutions. African Americans make up 13% of the population in the United States, but account for 57% of all new HIV infections. While the death rate from AIDS is dropping overall, the disease remains the

leading cause of death among African American people ages 25 to 44.

Is there anything we can do about it? A paper published this year in *JAMA* by John B. Jemmott III, Loretta Sweet Jemmott, and Geoffrey T. Fong looked at an abstinence or safer sex intervention for African American adolescents called, "Be Proud, Be Responsible." It was based on a number of theoretical perspectives and was conducted in Philadelphia among 659 African American adolescents. All of the interventions included the theme of making proud and responsible decisions to protect themselves and their communities from health risks. They added communities because this was a culturally sensitive intervention that they wanted to resonate with these African American children.

There were 3 groups: (a) an abstinence intervention that also mentioned condom use, but stressed delayed initiation of sex, (b) a safer sex intervention that indicated that abstinence is the best choice but stressed condom use, and (c) a general health promotion control group that received the same number of sessions but with no emphasis on either abstinence or safe sex. An adult facilitator or two peer cofacilitators led each intervention group.

Follow-ups were at 3 months, 6 months, and 12 months. At the 3-month follow-up, 12% of the abstinence group reported having sexual intercourse during the previous 3 months. The safer sex group was 16%, while 21% in the control group reported having sexual intercourse. However, at the 6-month and 12-month follow-ups, the results washed out. There was no effect of any of the interventions on sexual intercourse.

When asked about the use of condoms in all instances of sexual intercourse, at 3 months the clear winner was the safer sex group (64%). This is the group where condom use was taught and stressed. Again, after 6 months and 12 months, the safer sex group was significantly different from the abstinence and control groups. The safer sex intervention had the longer and more powerful effect in this study.

When asked a more subtle question about the frequency of condom use in the last 3 months, both the abstinence group and the safer sex group were better than the control group; that is, they said that they used condoms more frequently. This finding held after 6 months and again after 12 months. In fact, these interventions were effective in increasing safer sex in this population. This is an important study because it shows some success with prevention interventions, but, despite our many successes, we have much more to accomplish in prevention research.

Another issue where we need some help is homicide among young children. We hear a great deal about school shootings, but we need to know what to do to prevent this from occurring. We need better research in this area, and I am happy to report that there is some work being done. The Fast Track Program is looking at family interventions that might prevent conduct disorder in children—a major risk factor for the development of aggressive and violent behaviors.

Research now shows that children who feel connected to adults in their lives seem to have lower risk for all of the problems I presented today. The question remains: "How can we package this and teach it to parents?" Perhaps our greatest challenge is translating the science of prevention into practice. The goal of prevention science should be to improve prevention practice—yet a gap still exists between the two. Scientists complain that practitioners do not use prevention approaches that have been scientifically validated. Practitioners counter that prevention research findings are not always relevant to their setting or population and are not user-friendly; they are embedded in jargon-filled journal articles and are difficult for practitioners to access.

However, to date, prevention practice has had no need for prevention science and vice versa. Witness the D.A.R.E. Program: It is a drug abuse prevention program that is in 70% of the schools in the country, but guess what? It does not work!

There have been successful academic careers in prevention science with no concern for practice. One can get tenure and become famous without being concerned with practice. Witness the lack of collaboration among science and practice-based organizations like my own and various private foundations. This gap between science and practice is bad because practitio-

ners may not be using the best science-based practices available, and scientists may not be studying issues relevant to practitioners.

Fortunately, we have some models for bridging this gap. Abraham Wandersman at the Department of Psychology, University of South Carolina, has thought a great deal about how we can better translate science into practice for the benefit of both. Ultimately, practice is where the action is; as much as we scientists like to think that what we do is the ultimate, practice is really the ultimate, because our science eventually has to relate to practice. Wandersman focuses on what he calls the accountability movement—What is the glue that will hold together funders, scientists, and practitioners? Funding agencies are becoming increasingly concerned with whether what they fund actually affects practice and benefits the public. Researchers are going to have to increasingly ensure that their findings are user-friendly. To improve practice, great science is fine, but it is not enough. Findings must be disseminated. There has to be a technology transfer, but even technology transfer is not enough. Just giving somebody a few journal articles is not necessarily going to improve practice. Practitioners will use science-based prevention approaches when the use of these approaches is part of how those programs are evaluated; that is, when the use of science-based approaches is one of the criteria for demonstrating accountability.

To improve prevention practice, Wandersman believes we need to move to comprehensive quality programming—essentially having practitioners answer eight questions:

1. Why is an intervention needed?
2. Why should you use this intervention? You want to use this intervention because the science shows this is the best practice. So if answering a question is part of how programs are evaluated, that naturally leads practitioners to the scientific literature.
3. How will this new program fit in with other programs you already offer?
4. How will you carry out the program? This question is very important because it has to do with the fidelity of the program, that is, how well the program you carried out matched how the science said it should be carried out for best results.
5. How well was the program carried out? What are some of the outcomes?
6. How well did the program work?
7. What can you do to improve the program the next time? Asking these questions helps one with the evaluation and refocuses the program in order to improve it.
8. What can be done to institutionalize the program—to make it permanent? Answering this question helps practitioners in two ways: (a) it allows them to demonstrate the effectiveness of the program to funders and (b) it provides a way of evaluating the program to improve it.

Let me just close with two more questions. Are the prevention of disease and the promotion of health in children, youth, and families through behavior change impossible tasks? People at NIH have told me, "You cannot change people's behavior ... It is impossible ... You have to use drugs (Excuse me, pharmaceutical agents.) ... It cannot be done behaviorally." Can Head Start really produce lasting improvements in the cognitive and socioemotional development of children and youth?

In trying to answer both of these questions, I am reminded of a story I recently read in a book entitled, *Conversations with God*. The story is about a young girl who is at home drawing a picture at the dining room table. Her mother walks in and asks, "Sweetheart, what are you drawing?" The little girl does not even look up and answers, "I am drawing a picture of God." The mother says, "Sweetheart, nobody knows what God looks like." The little girl looks up at her mother and answers, "Well, if you would just let me finish!" I feel the same way about these questions. The answer to both questions is: "Yes. We can do it, if you just let us finish."

Luncheon I

KEYNOTE SPEAKER:

Jack P. Shonkoff
Dean, Heller Graduate School
Brandeis University
Samuel F. and Rose B. Gingold Professor of Human Development
Brandeis University

Researchers, Practitioners, and Policy Makers: Hanging Together or Hanging Separately

Jack P. Shonkoff, M.D., is the Dean of the Heller Graduate School and Samuel F. and Rose B. Gingold Professor of Human Development and Social Policy, Brandeis University. He currently serves as Chair of the Board on Children, Youth, and Families at the Institute of Medicine/National Academy of Sciences, and is an Executive member of the John D. and Catherine T. MacArthur Foundation Research Network on Successful Pathways Through Middle Childhood.

He completed his undergraduate studies at Cornell University, medical education at New York University School of Medicine, pediatric training at Bronx Municipal Hospital Center and the Albert Einstein College of Medicine, and fellowship in developmental pediatrics at Harvard Medical School and The Children's Hospital in Boston. Prior to assuming the Dean's position at Brandeis, he was Professor of Pediatrics and Chief of the Division of Developmental and Behavioral Pediatrics at the University of Massachusetts Medical School.

Dr. Shonkoff has received multiple professional awards, including a Kellogg National Fellowship, a fellowship from the National Center for Clinical Infant Programs, and the Distinguished Contribution to Child Advocacy Award from the Division of Child, Youth, and Family Services of the American Psychological Association. He has served on numerous professional and public interest advisory boards, including the Executive Committee of the Section on Developmental and Behavioral Pediatrics of the American Academy of Pediatrics, and the Governing Council of the Society for Research in Child Development.

Under the auspices of the Institute of Medicine and National Research Council/National Academy of Sciences, he as served as a member of the Panel on Child Care Policy, the Steering Group for the National Forum on the Future of Children and Families, the Committee on the Assessment of Family Violence Interventions, and the Roundtable on Head Start Research.

He has served on the editorial boards of a number of scholarly journals, including Child Development and Infant Mental Health Journal; serves as the Principal Investigator of the Early Intervention Collaborative Study, a longitudinal investigation of developmentally vulnerable children and their families; and is a member of the Board of Directors of ZERO-TO-THREE.

James A. Harrell: In introducing the speaker to you, my main responsibility is to invite you to pay attention to what he has to say. I have three reasons why I believe we should pay attention to what Jack Shonkoff has to say. The first reason is that he is smart. It is an important reason to pay attention because you may learn something new if you do that. Now, it is not sufficient

reason, however, because there are probably a lot of smart people in this room, and you could keep on talking with each other and maybe the same result would occur. The second reason is that he cares. Caring is an occupational hazard in pediatrics. If pediatricians did not care so much, they would have become radiologists or cardiologists and made a lot of money. However, they do care a lot, so they went into pediatrics. I suspect, though, that the room is also full of people who care. As that also is not sufficient reason to ask you to listen to what Dr. Shonkoff has to say, there is a third reason. That reason is that he connects things; he puts things together. I have heard him speak before in other settings where he has talked about bringing together education, health, mental health, social work, child development, and all the disciplines that are important for us to have as part of the mix as we work in this field. He certainly is a connector in that regard.

Today he is going to look at another set of connections that are equally important, perhaps even more important for us at this juncture: the connections of practice, research, and policy. We are beginning to make some changes there, and it is through the kinds of connections that Jack leads us toward that we are able to do that. So, when you get smart and caring and connections being made, it really is worth the price of admission. It certainly is good cause to pay attention to what Jack Shonkoff has to say.

Jack P. Shonkoff: Thank you, Jim, for that generous introduction. I would like to share some thoughts today about the issues that frame this conference. I really appreciate this opportunity, given the title of the conference, which alludes to both a time of rapid change and the challenges of partnership among the research, policy, and service delivery communities.

We will start with three cartoons representing issues that have always been salient in our field. The first portrays a typical Elizabethan drama. It is the end of the play and everyone on the stage is either dead or about to die, while two people sitting in the audience say to each other, "What a shame. With a little intervention early on, all of this could have been avoided." So, my first point is that the idea of intervening early and the concept of prevention are not new. This is not what distinguishes this rapidly changing time in which we live.

The second cartoon shows a meeting of medieval lords and kings. The caption says, "Sure, we need more research on alchemy, sorcery, and other things, but where is the money going to come from?" The limitation of resources for knowledge generation is also not a new challenge.

In the third cartoon, we are again somewhere in the Middle Ages, with a king exhorting his subjects. The caption says, "Essentially, this is a battle over turf." This, too, is not a new concept, as struggles over turf have been around since the beginning of societies.

Now I would like to say something about what is particularly distinctive about the period in which we live. One cover story in *The New York Times Magazine* focused on what life is like for affluent children in the United States. The general thrust of the article was that they grow up too quickly; they live on too fast a track for their own good; and they pay a real price for their precocious sophistication.

Another characteristic of our rapidly changing times is that the gap between the "haves" and the "have nots" is greater than it has been in a long time, and it is increasing in the face of unprecedented economic prosperity. Most important, those at the lower end are, in fact, falling further behind. What also is different about our current times, particularly for those who live in some of our poorest inner-city areas, is that the problems that children contend with as they grow up are very different from those faced by children in poor urban areas when Head Start was first established over 30 years ago.

Finally, a cover piece from *Time* magazine questioned, "Whatever happened to the great American job?" Clearly, we are in a period of dramatic economic transformation tied to increasing globalization. Consequently, the nature of work in the United States is undergoing fundamental change.

These phenomena have important implications for the well-being of young children in the

early years. First is the problem of the stress experienced by parents who are trying to figure out how to combine meaningful work experiences and rewarding family life. Much of this simply is related to the pressures of time on people who are working and also taking care of children. However, there are additional dimensions to this challenge that also are essential to acknowledge. One is the fact that there is an underlying insecurity related to work that is different from what was perceived not too long ago. In the recent past, if people had relatively good jobs and if they performed reasonably well, they could assume that they could hold onto those jobs for their entire working lives. That is no longer a valid assumption.

More important, as we move away from manufacturing to an information economy, the nature of work and economic opportunity are changing forever. A few decades ago, if a person did not have much education but was willing to work hard, he or she could earn a reasonable wage that would support a fairly comfortable standard of living. Unfortunately, the simple willingness and capacity to work hard is no longer sufficient. Now one has to be well educated. Desirable job opportunities in the future are not going to be there for those who are willing to work hard but have limited education. Thus, the stakes are now higher for early childhood development and later school achievement, as the consequences of not getting off to a good start are much more severe than in the past. These are some of the challenges that make this a very different time, and that intensify the challenges faced by programs like Head Start.

I now would like to share some thoughts about the issue of multidisciplinary partnerships. Focusing specifically on the early childhood agenda, I view research, service, and policy as three different cultures that share a common mission. Thus, trying to move among these different worlds is a cross-cultural adventure.

I will begin with the culture of research, and be overly simplistic to make my point. In thinking about early childhood intervention generally, and Head Start in particular, what can we say about what research brings to the table? First, researchers build conceptual models. They think about why things are the way they are, and they help us understand how to influence developmental change. Second, researchers test hypotheses and answer researchable questions, while adhering to the highest standards of methodological rigor. When push comes to shove how one went about the process of gathering information is often more important to an investigator than what was learned. I say that in a respectful and not a disparaging way, because we depend on the research community to be unyielding in its demand for high scientific standards.

In contrast to research, the culture of practice is characterized by its own distinctive features. Much of the knowledge in the service delivery world is empirical in the literal sense of the word. That is, it is based on doing things and learning from experience in a systematic way. It is also influenced by what we pediatricians call "clinical judgment," or what others often call "professional wisdom." This source of knowledge is tremendously important, but it is not bound by the demands of methodological rigor required in the world of research. This is where a confident practitioner says, "I know what the data say, but in my experience, ..." We have to listen very carefully to those messages because they are often a source of considerable knowledge, particularly in those areas in which scientists are constrained by significant methodological limitations.

Finally, and perhaps most important, service providers have to make decisions based on incomplete information. Researchers, in contrast, do not have to make decisions about doing anything, except for deciding the design of the next study. When all of the answers are not in, a researcher can say that he or she has to do another study. Service providers do not have that option. They have to make decisions, and they are always acting based on incomplete data.

Now we move to the policy world, where science is just one point of view, and it is not necessarily the most important. That is not to say that there is no place for knowledge in the policy arena, but it is essential that we accept the fact that science is not necessarily viewed as the only source of answers.

The policy environment has more complex and interesting rules of evidence. They are not as

clear as they are in research, but they often are clearer than in the world of service delivery. In the policy world, science must compete with values and common sense, which in many cases come in the form of a powerful anecdote or value pronouncement. Decision making in the policy arena is not directly constrained by what the data show. It involves a complex process of decision by negotiation.

The need for more partnering or collaboration across these three cultures is not a new idea. Those who attempt to build bridges among these perspectives understand how incredibly difficult it is to achieve success. Anyone who says, "We brought together researchers, service providers, and policy makers who shared a common goal, and it worked like a charm," is likely to be engaged in either denial or wishful fantasy. There is no way that this type of collaboration is ever easy.

Whenever one tries to bring together people who have been trained differently, or who think differently, it takes a long time for a cohesive team to really emerge. There are many difficult barriers that must be overcome, not the least of which is to achieve a level of comfort such that each can admit that he or she does not always know all the answers. In fact, an important positive milestone has been reached when a multidisciplinary group is confronting a complex problem and somebody says, "I haven't the vaguest idea of what we should do here."

I would like to say something about why tension is inevitable, regardless of how much goodwill people have. First, there are some fundamental differences between people interested in scholarship and those who are involved in advocacy. Scholars, when they do their work well, often focus on how much more complex things are than they appear. Good scientists are attracted to the challenge of research because of its complexity and ambiguity. In contrast, one lives or dies in the policy world on the basis of simplicity and coherence. Any policy maker who says, "This is really much more complicated than anybody realizes," minimizes his or her chance of having an impact. On the other hand, in the scholarly world, if one were to say, "This is all really quite simple and there are no alternative inferences," one is not going to get very far, even though many scientific breakthroughs reflect the elegance of simplicity. In order to cross borders effectively, one has to be comfortable with the balance between complexity and simplicity.

Researchers are interested in questions; advocates are interested in answers; and the best researchers are much more interested in the next question than they are in the last answer.

Scholarship requires reflection; advocacy demands action. It is not that simple to just say, "Let's get some researchers, service providers, and academics together, and let's move forward arm-in-arm to make a better world for children." However, the right balance of pragmatism, conviction, and skepticism is exactly what the field of early childhood intervention needs in order to grow.

Head Start is the quintessential model of collaboration among scholars, policy makers, and service providers. It has a strong conceptual foundation that has been clear from the beginning, and it has matured over the past three decades.

Now, here is where I think things get a little bit dicey, and I am going to take a chance and say some things that are critical because they must be said. The implementation of this beautifully constructed, "cross-cultural" collaboration that we call Head Start has been rather undisciplined. Sometimes this is related to limitations in the resources that are made available to do the job well. Sometimes it is related to a variety of other factors that may or may not be under the control of those who are providing the service. This is an example of the difference between formulating a policy concept and making it work. Creative legislation can be passed, signed, and enacted through the political process, but ultimately it must be implemented effectively. It is not enough to get a law approved, nor is it even enough to get the money appropriated. Implementation is where the rubber hits the road, and implementation in early childhood intervention has been very uneven. Moreover, we do not help children and families by pretending that sound implementation is automatic, nor by trying to hide the variable quality of human services delivery. Poor program implementation is a serious internal threat to the entire field of early

childhood intervention. Therefore, we have an obligation to shine a bright light on this problem and address it in an honest way.

The assessment of early childhood intervention impacts has at times also been misguided. If there is any dimension of this field that is crying out for a giant leap forward, it is the way we approach program evaluation. Everyone here knows some of the reasons for the problem, and I will just mention two. One issue is the challenge of measurement. Remember when researchers were trying to define and operationalize social competence and figure out how to measure it? We said at that time that Head Start was not designed to raise IQ but was focused on a broader range of outcomes. Then we used standardized IQ measures to assess effectiveness, because that is what we know best and that is what the political process understands. Then we spent half of our time explaining why evaluation results were not really meaningful because they were not measuring what we were trying to accomplish. So the obvious question is, "Why did we measure the wrong outcomes and why do we continue to do that?" In all fairness, it is easy to identify the problem, and much harder to fix it. In the area of measurement, we are not there yet.

The other challenge is the overall issue of accountability. Although outcome measurement is critically important and must be addressed, the central question is not simply whether intervention works. Rather, the important questions are, what do we mean by "work," and for whom and how. Furthermore, if families do not receive a service, we cannot evaluate whether it is effective. If they do not get it because they choose not to participate, maybe that is the fault of the service—or maybe it is acceptable for some recipients but not for others.

If we studied the treatment of cancer the way we study the impacts of early childhood intervention, people would be dying of diseases that we have the knowledge to treat effectively. If, for example, we designed a study of a specific protocol for cancer, and half the people in the experimental group did not show up for their treatment, would we conclude one way or the other about whether the treatment was effective? Of course not! Would we say, "Half the people in the treatment group did not get the treatment, but it probably works." Nobody would stand for that. Nor would we conclude that the protocol doesn't work, particularly if the treatment were based on sound theory. One cannot infer anything about the effectiveness of an intervention if the target population does not receive it. If the treatment were found to be variably effective, we would figure out who was cured and who was not, and why. Finally, if the treatment were clearly ineffective, we would not conclude that it isn't worth treating cancer. We would continue to offer the best treatment we have, and conduct further research until we found an effective protocol for everyone.

Many interventions in medicine work better for some individuals than others. If asked whether cancer treatments work, we would reply that in some cases we can produce remissions 100% of the time and there are some cancers for which conventional treatment uniformly fails. Is the appropriate answer therefore that we are 50% effective in the treatment for cancer? No. The answer is that we can cure some types but we do not have an effective treatment for others. The same is true for early childhood intervention. We have to move beyond global statements about efficacy and talk about that part of the population for whom we have effective methods of intervention, and that part for whom we need new ideas. Where we have effective intervention, we have to make sure that all eligible children are served. As important, we must identify that part of the population for whom the interventions we have right now are not enough, admit that they are not adequate, and try something different. We cannot pretend that all early intervention services are good enough, and keep on doing the same thing. We must disaggregate the early childhood population, and treat distinct subgroups differentially. We must continue to experiment, evaluate, and learn.

So where do we go from here? First, we must acknowledge that research, service delivery, and policy making reflect different ways of knowing, and we should understand the benefits of combining these three perspectives. It is not a matter of empirical data versus professional experience, nor is it a matter of an action-orientation versus reflective thinking. We must blend

these cultures in the service of keeping our "eyes on the prize"—which is not to defend what we are doing or what we believe too zealously, but to be open to new ways of working on behalf of children and families, and to become more effective in what we do.

In order to get a public commitment to funding in human services, one often has to promise dramatic benefits. Head Start is a wonderful example of a program that has taken on the burden of promising big payoffs. Now, if one promises large impacts, one ought to be held accountable. However, if the promised benefits are unrealistic, then there will be disappointments. Head Start, even when it is fully implemented and has all the resources it needs, cannot completely end school dropout, teenage pregnancy, violence, unemployment, and every other social problem in this country. We must be realistic about what we promise and not be defensive about what we cannot accomplish in one program. If we promise too much, we ultimately are being self-defeating. We must have reasonable goals, we must achieve them, and we must keep pushing the envelope to do better.

I would like to end with two final cartoons. The first shows two scientists at a blackboard with two sets of complex equations connected by a statement that says, "then a miracle occurs." The caption reads, "I think you should be more explicit here in step two." This is an important message for the early childhood community. We focus a lot on the front end—screening children and families, setting criteria for program eligibility, and enrolling participants in service systems. We also spend a lot of time at the back end—testing and measuring (6 months later, 2 years later, 10 years later), and then when we find significant differences in outcomes, we report how much impact we have had. We have to learn more about how services influence outcomes, and why some children and families do better than others. We need to understand more about what the ongoing process of intervention is all about, and how it is part of a complex, multi-dimensional ecology. In some situations, programs have major effects; in other circumstances, their impact is lost in a mass of other forces or circumstances that overwhelm children and their families. The point is that early intervention is not a miracle, and it cannot be viewed out of context. If we are not "more explicit about step two," we are not going to advance our knowledge base sufficiently to move the field forward. This is where the wisdom of service providers and families can help us frame compelling research hypotheses and shape our theories of change. At the same time, however, we must recognize that important questions cannot be answered solely on the basis of the experiences of practitioners.

In the final cartoon, we see the same two scientists studying a different set of equations. The caption says, "What's really depressing here is the realization that everything we believe will be disproved in a few years." What I would like to suggest is that it would be much more depressing if nothing we believe today is disproved in a few years. If we know as much right now as we are going to know 10 or 15 years into the future, our field will have hit a brick wall. When we review state of the art research from earlier decades, we sometimes laugh at what scientists used to believe in the past. We must recognize, however, that the researchers who wrote the classic papers were very smart. Therefore, we have to assume (and hope) that a lot of what we believe right now is going to be put up on a slide at a conference many years from now, and people will laugh and say, "Look at what they did back at the end of the 1990s in early childhood intervention."

This is why science and service delivery must be at the table together. We must balance the passion of advocacy with the constructive critical questioning of science. If we question something that stands up to close scrutiny, it reaffirms our efforts. If it does not stand up to the challenge, then we should search for a better way. Whether we are researchers, policy makers, advocates, or service providers, our professional pride should not lead us to the ultimately self-defeating assumption that everything we are doing now is absolutely right. We should embrace self-examination as a vehicle for growth, and recognize that critical evaluation and a willingness to consider alternatives are how we improve continually. In the end, this is the only way we will be able to achieve our ultimate goal—to make as big a difference as possible in the lives of young children and their families.

Luncheon II

KEYNOTE SPEAKER:

Eleanor E. Maccoby
Professor Emerita of Psychology
Stanford University

An Embarrassment of Riches: Partnering for High Quality Research and Programs During Head Start Expansion

Eleanor E. Maccoby, one of the most distinguished graduates of the University of Michigan Department of Psychology, is known nationally and internationally for her research on the social and intellectual development of children and her excellence in teaching. Dr. Maccoby was among the Washington, DC originators of the predecessor organization to University of Michigan's Institute for Social Research and was an early member of the staff of the UM's Survey Research Center. She has been a member of the faculty in Social Relations at Harvard University and at Stanford University where she was Chairperson of the Department of Psychology and is now Professor Emerita.

Dr. Maccoby completed her undergraduate studies at Reed College and the University of Washington, and her graduate work at the University of Michigan. Her research interests include socialization of the child; the development of sex differences; parent-child interactions in a developmental context; selective attention in childhood and old age; the effects of television on children's behavior; and compensatory education.

Multiple professional awards include the Barbara Kimball Browning professorship at Stanford University; the Walter J. Gores Award for Excellence in Teaching; the G. Stanley Hall Award from Division 7 of the American Psychological Association; the American Educational Research Association Award for Distinguished Contributions in Educational Research; and the Society for Research in Child Development Award for Distinguished Scientific Contributions to Child Development. She is one of the few behavioral scientists who has been elected to the National Academy of Sciences.

Her professional activities include membership on the Board of Scientific Counselors, National Institute of Child Health and Development; member of the Institute of Medicine and Program Committee of Institute of Medicine; member and vice chair of the Committee on Child Development and Public Policy, National Research Council; member of the Governing Board of the Social Science Research Council, and president of the Society for Research in Child Development.

John Hagen: It is a pleasure for me to be able to introduce Professor Eleanor E. Maccoby. I am especially proud to say that she is a past President of SRCD and she is also a member of the National Academy of Sciences—a position that comes to very few in the behavioral sciences. However, my experiences with Eleanor have been much more personal and go back a very long way. I was her graduate student, and in every sense of the word she was my mentor and continues to be my mentor today. Thanks to e-mail and frequent meetings, we are able to correspond on a regular basis.

Eleanor Maccoby's interest in and commitment to children and families and to applied issues has a long history. One of the things that I remember most about Eleanor, going back to the early 1960s when I was a student, was her genuine commitment to the application of our scientific knowledge base to the important issues in society. In fact, it is fitting that she is speaking at our Head Start Research Conference because in the summer of 1964, when Head Start was starting, she was asked to consult to a Head Start program. She took me along and at the time I did not even know what Head Start was. I think she was not quite sure what it was either. Not long after that, she took several graduate students to Oakland to visit a child care center being run by the Black Panthers. That was an interesting and scary experience. We were asked to critique their program. In the intervening decades, Dr. Maccoby has been interested in many topics and issues, and one thing that characterizes Eleanor is that she calls it as she sees it—or calls it as it is. She also surprises people who assume she will have a certain point of view. She has probably looked at the literature and perhaps made a different interpretation, and she will always let people know her opinions.

I know that Eleanor is very impressed with what has happened to Head Start over the years. It has certainly gone from a social experiment to becoming the largest federal program for children that has ever existed. Many of us now feel that it is the beginning of a new era with many more resources available. That is the theme of her talk. She will be talking about this period of riches and how to maintain high-quality research and high-quality programs as Head Start moves into its new era.

Eleanor Maccoby: It is wonderful to be here with you, especially having begun my interest in Head Start so long ago and having watched the wonders that you all have wrought. This is a moment for congratulations. It is true that Head Start has always had its enemies who have wanted to spend public money on something else. However, I think that Head Start is so firmly established in the public domain that the program has widespread support. My prediction is that it also will go well in the new funding period.

The funding for Head Start has doubled since 1992. Before that time, with a different administration, there was also considerable expansion. There are many ways to use these additional resources: (a) We could simply serve more eligible children in the same types of programs we now have—we are now serving almost 50% of the eligible 4-year-olds and a much lower percentage of the eligible 3-year-olds; (b) We could expand some or all of our traditional half-day programs to full day; (c) We could expand Head Start downward in age to serve infants and toddlers; (d) We could use our resources to improve the quality of programs, such as devoting more time and effort to staff training and paying better salaries; (e) We could do all of the above or some combination of all of them. All of these options are currently being pursued, and surely we want to continue to some degree in all of these directions. However, it is important to give serious thought to maintaining a balance among them. Let us consider each of these options for expansion in turn.

We are now serving about half of the eligible 4-year-olds and only a little more than one quarter of the 3-year-olds. This number has greatly increased over the past few years, but there is a need to create more places in our traditional half-day programs, especially for 3-year-olds. This would enable us to be true to the original concept of Head Start: promoting school readiness in children from low-income families by enhancing their cognitive and social development in a well designed preschool program. The design of these programs was originally based on the latest theory and practice in early childhood education that had initially been used in schools with children from more affluent families. Head Start did add other elements especially pertinent to poor children, such as medical checkups and services, involvement of parents, including home visits and as volunteers in classrooms, and cultural sensitivity and bilingual approaches where needed.

When we ask why Head Start has not served a higher percentage of eligible children, the

obvious answer is there has not been enough money to provide enough places. That is not the whole answer, however; many eligible families do not apply, even though we might think they need the service. I recently visited the programs in Santa Clara County, CA, and was told that they now felt they could find a place for every eligible 4-year-old who applied, but that there were so many who did not apply. The reason for this is that their parents were working and needed full-day services.

With this information, we have begun to expand to full-day service, which has not turned out to be easy. The changes in welfare policy have required parents in poverty to go to work or enter job training programs, which has meant that these parents have great difficulty coming in the middle of the day to deliver or pick up their children. In addition, they may not have access to transportation needed to take the children from a Head Start center to the child care they have arranged for the rest of the day. Therefore, even parents who would love to have their children in Head Start are not able to manage it. There is probably a widespread consensus among us that Head Start should use some of its new resources to expand existing programs to full day.

What sometimes happens is that a Head Start center, which has been functioning as a half-day program, will simply stay in the same facility and expand to full day. However, this usually means one has to hire additional help or extend the working hours of those who are already on the staff, which becomes much more expensive. Also, those programs that have two programs, one morning and one afternoon for separate groups of children, have found it very difficult to expand their programs to full day. In addition, for these programs it would mean serving only half as many children. Therefore, many of these programs have decided to maintain their existing half-day programs in the same place while expanding to full day by opening new centers as they have done in Santa Clara County.

The pressure on the staff, however, in full-day programs is not something to be looked upon lightly. It has turned out to be quite difficult to find the time that is needed for home visits, for example, if you work a full day in a center. Another discussion has been about the personnel needed in a full-day center. Some have argued that children do not need to be "educated all day long."

There are, however, some basic philosophical and educational issues being argued within Head Start programs. Head Start was not established as a child care program and many believe that the process of taking care of children and simply providing a safe place for them should be distinguished from the kind of educational experience to promote school readiness that Head Start offers. If Head Start were to dilute this objective, one might not need to have the same level of skilled personnel for the entire day. In fact, one might dilute the central objective if what is done for the rest of the day is simply provide a safe, supervised place for children to be while their parents work.

Others argue that one should not try to distinguish the care functions from the kind of educational experience that Head Start offers. They go on to say that the two should be part of a seamless day. It is better for children to be in the high-quality environment that Head Start has always provided all day long, rather than part of a day. It does not make sense to try to have two levels of staffing. I think that is the direction in which I will lean.

However, I must say that I am only beginning to be educated about this subject. The hard fact remains that with extended day programs there is more pressure on the staff. Someone has to come early to meet the parents and someone has to be there late when the parents return. There has to be time for staff to have an opportunity to talk to the parents about what has happened to their children during the day. This is very difficult to accomplish without putting undue pressure on staff. I see important research issues here. Can the quality of half-day programs be maintained when the programs move to full day? What conditions determine whether or not quality is maintained?

There are some trade-offs in this approach. With only a given amount of money, there are fewer children served in full-day programs than were served in half-day programs. However, I

have recently talked with some people who have been facing up to this problem. It turns out that there are very creative ways and means of supplementing the money that one has when one moves to full day. Yolanda Garcia, the director of the Santa Clara County program which has 60 child care centers including six new full-day programs, has found that it is possible to blend Head Start funds with some of the newly available state child care funds. This allows them to stretch Head Start dollars in such a way that their programs can become full day without greatly increasing Head Start costs. In sum, it seems to me there is every reason to extend to full day, and it is obviously necessary. We are simply going to have to be innovative about finding the money to accomplish this.

There is now a mandate to set aside 10% of the Head Start budget for Early Head Start. Since we are now increasingly aware of the importance of the first 3 years of life, extending its program for children from birth to 3 is another way in which Head Start could use extra resources. In yesterday's symposium on brain development, the latest information on early learning was presented. We heard that the sensory and motor systems develop during the 1st year and that the 2nd and 3rd years are critical for the development of language and the capacity for self-regulation. We also heard about the great effect the experiences children have during that period have on the processes of brain growth.

In an article in today's *Washington Post*, William Raspberry cited some of this research, concluding "that the most important thing about these findings was that if the right things did not happen in the first 3 years it was too late and that these losses were irreversible." We need, therefore, to focus heavily on these years of rapid brain development.

In yesterday's symposium on the brain, Michael Meany presented some marvelous data from studies with lower animals. These studies showed that the effects of early deprivation were very real and could be demonstrated in the way the brain functions. However, he said, these effects could be completely reversed by an enriched environment later. What we now have opening up is an area of research showing us just how critical these periods are. It was very encouraging to hear that the brain remains more flexible than previously thought. This does not change the fact, however, that the early years are crucially important.

When thinking about working with younger children—infants and toddlers—it is important to remember that this is a very sobering enterprise. Every time one begins to work with younger children, the expenses increase. It is almost always more expensive than the center care that we are all used to in our traditional programs. We must ask ourselves, "What population of children do we think we need to serve? Should we serve all of the children who will become eligible for Head Start (meaning all of the families below a certain income level)?" We also need to know how many of these children actually need intervention in order to ensure the conditions for adequate brain development.

What are the conditions that a child should have in the first 18 months of life? My personal view is that they do not require a great deal of cognitive training and stimulation, and I recognize that there are certain people who think otherwise. In Marin County, there is something called the Prenatal University that has a logo showing a fetus in utero wearing a graduation cap. This group recommends shouting through a megaphone placed on the abdomen of a pregnant woman in her eighth month. The theory is that this will help the infant to learn very quickly after birth. This sounds absurd, right?

What we know is that babies and toddlers in these early years need nurturance: face-to-face, reciprocal interaction, responsiveness from their caretakers, the "licking and grooming" that we heard about from Michael Meany yesterday, as he described nurturance in animals farther down the phylogenetic scale. Can families eligible for Head Start provide these necessary conditions? Jack Shonkoff warned us in his luncheon address about the very different meanings there are to the words we are so fond of, such as deprivation, disadvantage, and being at risk. Norman Anderson, in his opening keynote address, told us that poverty itself is a risk factor.

When trying to decide which infants and toddlers should be eligible for Head Start, the first

definition I would use is deprivation or disadvantage. However, it is important to keep in mind that many families, despite poverty and disadvantage, can provide the nurturance and responsiveness, the "licking and grooming," that infants and toddlers need for adequate brain development—I will call them "disadvantage type one." Some families, however, cannot provide the necessary nurturance—I will call them "disadvantage type two." These are the children seen in Head Start centers at the age of 3 or 4 already handicapped with a variety of mental health problems that probably come from abuse or neglect, or simply from being a part of dysfunctional families. These children need the kind of early intervention found in Early Head Start programs.

Families who are "type one" disadvantaged, that is, who are poor, but not dysfunctional, need different kinds of national programs. They should have income-supported parental leave as one of their choices. This would allow more people who wish to be at home with their young children to do so and not be forced to go to work. In addition, for those who can, must, or wish to go to work when their children are very young, we need to have decent subsidized child care. These programs are the business of the nation over and above what Head Start can or should do.

I do not think that Head Start should try to fill the gap in our patchwork child care system. We have to focus ourselves more on the kinds of things that we do best. This implies that we would have a screening program for a targeted population. I recognize the dangers of screening—it can involve labeling and treating people in ways that can seem to be demeaning to them. However, we obviously need to focus some of our research on the problem of choosing who our clients should be for Early Head Start. I believe that both parents and children in "type two" families can benefit from well-designed interventions.

We already have excellent experimental studies of the effectiveness of interventions designed for at-risk infants and toddlers. North Carolina has been one of the leaders in this type of intervention. The results of their Infant Health and Development Program (IHDP), where they worked with low birth weight babies, showed very clearly the advantages of well-designed interventions for children at risk. We know that these programs can be effective if they are properly implemented. We also know that programs designed for infant and toddlers need to be quite different from those designed for older children. It seems clear to me that early intervention with children who will later attend Head Start might make a difference in their ability to profit from Head Start when they get there.

The Administration for Children and Families (ACF) has launched a large-scale study of the effectiveness of Early Head Start. They will specifically assess whether the children who are enrolled in Head Start infant and toddler programs do better when they go into regular Head Start programs at preschool age. We all eagerly await the results of these studies, and hope that their data will give us new insights into how to intervene and with whom.

Another form of using our resources is to improve the quality of existing programs. Until recently, the quality of Head Start programs was quite uneven. However, the Advisory Committee on Head Start Quality and Expansion now has up-to-date, outcome-oriented performance standards reflecting best practice, along with systematic assessment and monitoring, set in place. The latest ACF data, taken from a large number of programs, shows that the average quality is good and it is much more uniform than it previously had been. There are still serious problems with the pay scales for head teachers, and there continues to be difficulty in recruiting new people with the level of education and training needed to manage a quality Head Start program.

It has been axiomatic to most of us that we need still better trained staff, smaller group sizes, and greater one-on-one interaction between teachers and children. I am sure it is obvious to all of us that it is important to maintain and improve quality. There has been a large body of research on what the elements of high quality are, and there is probably agreement among us about what we mean by quality. We know that we should not say "do not" to children all the time, but rather tell them what we want them to do. The need for discipline should seldom arise if a program is running well. Opportunities for learning should be abundant; there should be

more frequent interaction between adults and individual children. Children should form emotional bonds with at least one teacher. We believe that all these things are more likely to happen if we have well-paid, well-trained teachers, low staff turnover, and relatively few children for each adult staff member.

The definition of quality, however, should not remain static. Ed Zigler, in his recent testimony before Congress, said that we ought to continue to remember that Head Start was originally created as a national laboratory and that we should continue to pay attention to the curriculum that we offer to our children. There have been comparisons between the didactic and heavily academically oriented curricula that teach children letters and numbers and the more play-based, discovery-type programs. It is time for us to consider broadly the kinds of curricula that incorporate more social behavior and moral development. It is true that our Head Start objectives have always included social and emotional competence, but they have not taken these elements of growth as being especially important for school readiness. In fact, most of the outcome variables have more to do with learning certain cognitive skills.

We have thought of social and emotional development too narrowly. This is something to be achieved by adult teaching and example, so that Head Start teachers will intervene in fights, separate children, talk to them about how it started, and suggest to them that they do not need to hit with sticks, that they can use words. Children can be taught to share and to take turns by the teachers. They can be read stories with moral lessons, and so on. I would like to suggest that we are all too oriented toward what adults are doing to and with children and not nearly oriented enough toward how children behave toward one another. For preschoolers, their relationships with their friends and peers in the classroom are of absolutely paramount importance in their adaptation to group life and their readiness for school. The power of group process should be harnessed in the interest of school readiness.

In her book, *Educating Hearts and Minds,* Catherine Lewis describes some of her observations made in Japanese preschools (I know all of you are thinking, "Oh, my God, not Japan again"). Nevertheless, I think it is worthwhile to think about how they harness group process. They spend far less time on academic training than we do—about 5% of their work in preschools is spent on teaching letters and numbers, whereas something like one third of our preschool time is spent on these subjects and other similar concepts. The Japanese focus instead on social behavior and social relationships. When their children get to first grade, they then learn the academic content much faster than our children do. My point here is that focusing on social relationships is not something that one does instead of getting children ready for school, it is a way of getting children ready for school.

The Japanese make use of group process in a much more comprehensive way than we do. They include this as one of their objectives that they refer to as "trying to develop character." This involves some individual goals, such as being true to one's principles and finishing what one starts. However, there are other goals that stress behavior "in relation to others." These are being trustworthy, keeping promises, being considerate and kind, participating in group activities cooperatively, being responsible and doing one's share, and taking initiative in group context.

Japanese preschools take advantage of both small group and larger group processes in a number of ways. Small groups are carefully thought out and put together at the beginning of the school year. In these groups, about five children will be together for a full year or longer. They engage in joint projects, sit together at their table for their snacks and their lunch, and put their sleeping mats down next to each other. They have a group name, such as chrysanthemums, and are known by that name by the other children. Each group appoints a monitor for that day, and it is that child's job to make sure that everyone in their group has juice, lunch, and so forth. If a child wants more juice, it is their monitor who gets it for them. No child would think of asking the teacher or teacher's assistant to do that for him or her. In this way, the children take over more and more responsibility in the management of the classroom.

Every day there is a group meeting where the children reflect upon what happened during the day. The teacher may have observed various episodes that happened during the day that were not to her liking, but she did not intervene, unlike an American teacher. However, at the end of the day, the teacher brings up all of these situations, talks to the class about them, and asks the children their opinion about what happened. The children discuss who was right and who was wrong. Each of the small groups reports on how they did with their chores that day.

In one observation, Lewis reports that one group that was supposed to clean out the guinea pig cage said, "Well, we did not really do very well, because two of the children in the group had been playing around and did not help." The teacher then asked, "What do you think should be done about it?" The children in that group responded by saying that maybe the ones who want to work should take care of the guinea pig, and the other ones do not have to. The teacher then asked the whole class if they thought this was fair and they responded that they did not think it was fair and added suggestions as to what should be done instead. The point is that the teacher did not answer the question for them. Day after day, the children were required to figure out their own way of handling these interpersonal problems. By the end of the year, the children actually developed a sense of taking care of the other children who were in their own group and being responsible about finishing up their chores, and so on.

It seems to me that this is not a bad thing to be teaching children, but we have to ask ourselves whether this would work in an American setting and would we really want this in our preschools. We are not particularly pleased by the idea of asking children to criticize each other in front of the whole group. However, this approach also involves suggesting ways that one can help other people and praising a group that does more than its duty in helping the whole classroom. One caution is that group power can be very coercive unless it is combined with kindness. I think this approach has an almost totalitarian feel to us.

We do, however, need to think about what can be done within our own values and what would be useful in American schools. It certainly would not be just like what happens in Japan. For instance, the children who come to our schools, particularly our Head Start centers, are probably quite different from the ones in Japanese schools. We are a more individualistic people than the Japanese are and we do not necessarily want our children to be subject to group pressure or compliant to it. We are also more likely to think that training children in moral character is the job of the family and/or the church. Yet, more and more observers of our national life and national character have begun to say that we are carrying our individualism too far. We no longer know the modes of cooperation and group activity that once characterized our earlier history.

We have recently begun to hear more talk about the need for social capital. Building social capital has to start early, just like all of the other things that we know have to start early. It can start in Head Start classrooms if we think seriously about changing our curriculum to include the goals of having children feel responsible for one another and being kind to one another. You might wonder if this is antithetical to the goal of school readiness. I do not think it is. This might be an easier way to deal with aggression than behavior modification where children are given points for buying a candy bar if they behave properly.

An example that comes to mind is the most recent work of Angeliki Nicolopoulou. She is doing program process in a different way. During the day, each child can tell the teacher a story and then, at the end of the day, they have an all-classroom session where that story is acted out. The child who told the story selects other children in the classroom to play the roles in the story. At the beginning of the year, they hardly know how to do this, but by the end of the year this is the most enthusiastic activity you can imagine. She has been doing this with the Head Start class this year. Children, it turns out—it is an unexpected gift from this work—are doing far better with productive language by the end of the year, even though that had not been the objective of this program at all. There can be spin-off benefits to group process, not only in the social realm, but also in cognitive gains.

There is another kind of spin-off, which I almost hesitate to mention. Japanese preschools are under good control and are well managed by one teacher with 40 children. There are no assistant teachers and no volunteer parents in the classroom. We are not going to be able to duplicate this, but we could manage to serve more children in our programs without escalating the costs and without having to increase staff sizes by incorporating the methods that give some of the management responsibility to the children themselves.

This is very difficult for us to do because it is not indigenous to our culture. However, there is nothing wrong with trying some of these methods. What I am proposing is a modest program of experimentation on Head Start curriculum. There has been considerable research contrasting didactic, academic-style teaching programs for preschoolers with "discovery" and more play-based programs, and this change would be true to the original concept of Head Start as a national laboratory for the development of innovative educational practices for young children. I suggest that we start experimenting with ways to focus more on group processes and use them to build cooperative values and behavioral repertories in our children. This, of course, would need to be included in the program performance standards, and performance measures that reflect progress in this domain would need to be available.

We need to be aware of some current claims that variations in the quality of out-of-home care do not matter much for children's well-being and healthy development. It is startling to me that one of the strongest voices saying this is our own Sandra Scarr, who was President of SRCD. In a paper she wrote last October in *Current Directions in Psychological Science*, Scarr says, "Given the variations in child care quality from dreadful to excellent, the major question is, do vast differences in quality of child care programs have an important impact on children's development? The surprising conclusion from the research literature is that variations in quality of care, rated by experts, proves to have little or no impact on most children's development." She restated this same message in a recent issue of the *American Psychologist*. This is very strong stuff, and it is unexpected from a person who, with Kathleen McCartney, did the pioneering study of child care quality in Bermuda in the early 1980s. Their findings showed that, indeed, variations in child care quality were closely associated with children's language skills and other aspects of their development.

Perhaps one reason for her current viewpoint is that she thinks that in earlier studies we did not take into account the fact that better functioning families self-select higher-quality preschool programs, so that what we thought was effective quality actually reflected preexisting characteristics of the families and their children. There is not time to go into the complexities of this self-selection issue, but I think that some of the work just now coming from the FACES study has addressed this issue. When their longitudinal data begin to come in, we will be able to partial out initial status. It is important for this to be done in order to meet exactly the kind of criticism that Scarr has mounted. I believe that the importance of quality in child care can be supported, despite the issues that she raises. Concerning her position as it stands, let us note two things: She is talking about child care, not developmentally oriented, educational, preschool programs designed for poor children, and although she describes what she means by high-quality programs for preschoolers, it does, in fact, sound very much like what Head Start has tried to put in place.

Scarr does say in both papers that children from disadvantaged families are an exception. In the *American Psychological* paper's abstract, she says, "Widely varying qualities of child care have been shown to have only small effects on children's current development and no long-term effects, except in disadvantaged children whose homes put them at developmental risk." It might seem that this makes the larger issue of the alleged weak effects of child care quality irrelevant to us, since Head Start deals exclusively with disadvantaged children.

Scarr's challenge does actually matter to us because of the political and policy context in which it is embedded. Why is she saying these things so forcefully just now? It seems strange from someone with her history. I think it understandable in a certain way, because she believes

that there is really an urgent need for more child care places, and she is right about that, especially for working families. She thinks that the very poorest and the more affluent families do have decent quality child care, but that people in the middle range, the working poor, are the ones who have the worst child care. She notes that quality improvements absorb a large portion of the resources that would otherwise be available for increasing the number of child care places. In other words, the most expensive thing one could do is to raise quality by raising salaries and reducing group size. Perhaps the most important element in cost is maintaining a favorable child/staff ratio and small group size. Spending money and time on staff training has the same effect. If this were done, families who must pay for their own child care would be priced out of the market. If this were done for subsidized programs it would mean fewer children could be served and the acute shortage of places would continue to become worse.

These are very serious tradeoffs. Scarr is right to call our attention to them. It is a heavy price to pay for maintaining what we see as quality standards. It does matter for Head Start where we need to serve more children within the constraints of the resources that we have. The most recent ACF data, the FACES study, show that specific aspects of program quality, (e.g., variety and caliber of language-learning opportunities) are related to children's progress in vocabulary acquisition. Presumably, one important value of favorable adult/child ratios is that with fewer children to work with, adults can provide more one-on-one language learning opportunities for each child.

We need to ask ourselves, "Must we hold tightly to all the quality standards that we love so well, if it means that we cannot serve all the children who need to be served?" As an answer, I say that is the reason I brought up the Japanese example. I do think that there may be ways and means whereby we can manage to keep the quality standards that truly matter in place. We can start to do research on ways and means of stretching our resources by reviewing what our quality standards really are. I know that the ACF is thinking seriously about quality standards, and understands that they are not fixed in stone. The ACF is a wonderful example of a bureaucracy that is responsive, one that is moving with the times and, in fact, is out ahead of the curve. Congratulations are in order.

However, I should note that if we try to move in the direction of greater utilization of children as self-managers in their classrooms, we would need more skilled teachers even than we have now. It is going to take more money to pay higher salaries and train people, partly because it is not quite so consistent with our own histories or culture as it might be in other cultures.

None of us wants to make the hard choices among offering full-day programs to more families, enrolling more 3- or 4-year-olds eligible but not now enrolled, serving more infants and toddlers, paying better salaries to Head Start teachers, and spending more on training. We are now trying to do all of these. However, our resources are still limited. We would benefit by research aimed at discovering ways of making our resources go farther, without sacrificing the wonderful gains we have made in providing high-quality experiences for children and families.

Plenary I

Continuity and Readiness: Sharing the Responsibility

CHAIR: Sarah Greene
PRESENTERS: Reid Lyon, Carleatha Johnson, Rita Moore, Grover Whitehurst
DISCUSSANT: David Denton

Sarah Greene: In this plenary, we will focus on the dual perspectives of adequately preparing Head Start children in preschool for school and also readying schools to receive our children.

Reid Lyon: I am going to be describing the National Institute of Child Health and Human Development's (NICHD) program of reading research, which has been in place since 1965. There are three basic questions we are trying to address. First, how do children learn to read? What is it that goes into that? What are the skills, the abilities, the environments, and the combinations among those factors that produce robust reading in youngsters? Second, given that we have substantial numbers of children not reading well, what gets in the way? Which of those abilities, skills, environments, or their combinations, seem to hinder children's ability to master written language? Third, a critical and practical question is which teaching interventions are most effective or beneficial for which children at which stages of development? To presage the rest of the conversation, clearly one size does not fit all. The typical dichotomies and polarizations, for example, phonics or whole language, do not make a great deal of sense. Most people who work with children at a clinical or classroom level know that. The real question is to determine with substantial robust evidence what kinds of strategies we can use with children at which stages of their development to produce rapid, fluent reading.

The NICHD has 41 sites in existence around the country addressing those three questions. Our program in reading development is fairly unique in that the majority of the studies are longitudinal. They generally start with children 5 years of age, not knowing if they are going to be good or poor readers. We follow them for varying lengths of time, anywhere from 5 to 20 years. We have some children now who are 22 who have been with us since 1983. Other children are now 17, some are 9, and others are 7.

We bring to bear a number of disciplines in trying to understand the three questions. Trying to understand what it takes to learn to read requires people who understand reading in a very deep fashion. We employ researchers who understand the developing brain as well as people who understand cognitive, affective, and social development. We try to understand what it takes cognitively to learn to read, what it takes linguistically to learn to read, what it takes biologically, particularly neurobiologically, to learn to read, and which genetic features push that neurobiology to allow many children to read quite easily and which are the ones that get in the way.

The studies are multidisciplinary with large numbers of children that represent all socioeconomic, ethnic, regional, and geographic strata. They are population-based, epidemiological, longitudinal studies. Since 1964, we have studied 34,000 children. The majority are normal readers. To understand typical reading development, one needs a good idea of how different kinds of children achieve reading success. Currently, we have approximately 7,000 children in intervention studies. I will try to address the results of some of the early data that are coming in from those studies.

All of you who work clinically or in the classroom know how devastating difficulties in learning to read are. Poor reading has deleterious, devastating effects on children throughout their lives. In kindergarten, first, and second grade, we see children who are sometimes very vibrant, energetic learners. By third grade, we see youngsters who are demoralized with low self-esteem, and who, no matter how strongly we get to them instructionally, simply do not want to partake in the process. That is why Head Start is so critical. I will make the point today, given the longitudinal work that we do, that if we do not reach these children early and powerfully, we will lose them. There are 34,000 children in these samples that tell us that clearly.

Some children we have studied have shown a behavioral characterization seen with children who do not accomplish the reading task easily (i.e., slow, laborious pulling of print off the page). This constrains or removes the ability for them to comprehend what they just read because so much cognitive energy went into the decoding process that they cannot respond to comprehension questions. On the other hand, if we pull the book away from these youngsters and read the story to them, they will talk to you all day about it. What is it that gets in the way of being able to, in a facile, fluid fashion, pull print off the page so that one can relate that information to what one knows? Understanding and enjoying reading and using it to enhance knowledge is what we would like children to do with reading. These children cannot do that.

What gets in the way is the second question. Obviously, it relies on the first question. What does it take to learn how to read? About one in five children shows slow laborious reading behavior, about the 20th percentile and below. What is amazing and also sad to us, as we follow the general population through the longitudinal epochs, is that children who read at the 30th and 40th percentiles are sometimes equally at risk for poor reading. Because again, even though those youngsters would not be identified for special education or specialized assistance, their reading speed and accuracy are so labored and slow that they do not respond well to information gathering through text.

So when we state that about 20% of the children in our sample show difficulty in decoding and word recognition, I suggest to you that that is a conservative figure if we are talking about individuals downstream who are going to use reading for learning and enjoyment.

We have 15-year-olds whom we have followed from 5 years of age. We ask them, "Do you read?" They reply, "No, I don't read. I'd rather watch TV or look at videotapes." We ask, "Why don't you read?" They say, "It's too hard." There are not many of us that continue to do behavioral tasks when they are too hard.

What does it take to learn how to read? Researchers and others in the field have converged on a primary factor: Children need to understand that the language that they hear is composed of distinct individual sounds. The term is phoneme awareness. Learning how to read requires understanding sound structure. Since English is an alphabetic language, when we convert our listening and speaking capabilities into print, we have done so through conventions of mapping sounds, 40 to 44 of them in our language, to 26 letters. Although that may seem like an easy task that would come naturally, it does not. It is a very difficult task.

When people are talking with one another without any print in front of them, any word that is said, such as "cat," comes by the ear. If asked how many sounds were heard in the word "cat," typically someone will respond two or three. However, the ear only hears one sound in any syllable level utterance or beyond. The reason is nature has provided us with a very rapid communication device, such that when I say a word like cat or bag or big, the middle and ending sounds fold up into the initial consonant. They coarticulate. The minute I say "cat," the "a" and the "t" sound fold up speech-wise, acoustically speaking, into a fairly large burble of sound, fly by the ear, and the brain then must recover these individual sounds from running speech. That is not easy to do if one is genetically predisposed not to recover very small sounds. It is also not easy if one has not had any experience playing with language, such as reciting nursery rhymes, talking with parents, and conversing. There are multiple avenues to difficulties in phoneme awareness. However, it is at the foundation of learning to read, because when

children learn to read English or any other alphabetic language, their task is to break a code, to decipher a cipher. The cipher requires the examination of visual information and then laying these smaller units of sound upon the individual units of that information. If one does not understand that words that one hears are actually composed of smaller units of sound, the puzzle remains a puzzle.

One of the main predictors of this slow labored decoding and word recognition is the ability to rhyme. If we ask a 5-and-a-half- or 6-year-old to provide some words that rhyme with cat, that child will typically say "sat" or "mat." If we ask a would-be poor reader, she would say something like "dog" or "kitty," even after we taught her the concept of rhyme. Why? To be able to rhyme anything with cat, one has to slice off the initial sound, the "ka" sound, and replace it with another sound. How does one slice a sound off if one does not know that there are three sounds in the word that to the ear sound as one blast of energy? That is why rhyming is a fairly good predictor of how children manipulate sounds and are able to map them onto the print in front of them. Older children do phoneme deletion tasks. If asked to say "big" without the "buh" sound, a would-be good reader will say "ig." Others will have a difficult time even understanding what is meant.

Phoneme awareness is a difficult concept to explain and is also complex. However, it is a critical linguistic capability. The script that we read requires in the acquisition process the mapping on of small individual units of sound that the ear in fact cannot hear. It is the brain that hears those, but it is also massive amounts of experience that teach the brain about that. Children will not master this particular subtle, albeit critical, linguistic capability if they do not interact with language in a vibrant, exciting way, such as playing with sounds and doing things that highlight the sound structure of the language.

We clearly can see a predisposition toward very slow, labored decoding with some children even though both parents are professionals. Despite massive exposure to reading and interaction with language, some children still cannot negotiate reading very well. There are multiple avenues to this foundational capability.

In conversation, one does not have to understand how words are spelled. It is not an issue for listening and speaking. It is, however, a critical issue for reading. Reading is not a natural process. It will not come about in many children just by reading to those children.

We can interact with children through listening, speaking, and reading to them, but if we find that they stumble over the basic units of language, even though they can converse robustly, they are going to be slow and labored in their pulling off of the page the print that gives them the knowledge. Children must master the application of the sound structure to the letter code, to the alphabet. They must develop the alphabetic principle. One cannot learn to read if one does not know phonics.

Unfortunately, we have an alphabetic language that is a code. However, in our studies in China and Japan, of which we have several, we also notice that in logographic languages, pictorial languages, a great deal of this sound structure is also needed. In Chinese characters, several elements of one character relate to the intonation and the sound. Phoneme awareness is predictive of poor reading in Chinese.

Phoneme awareness is a necessary but insufficient condition in learning to read. That sound structure must be mapped to the alphabetic script. Phonics is necessary because our language when it is read must be decoded. All of us continue to use phonics even at our age when we confront words we have never seen before.

In contrast to what has been thought before, using the context of the script to predict or to help to read words one does not know for the most part does not work. There are only about 10-15% of the words in our language that can be predicted in script. It is not good practice to teach children to use context to predict what words might say. That is a strategy poor readers use. Good readers go into the internals of the word and sound it out. Context is critically important for comprehension, but it is not a successful element in predicting words one does not know. That is very hard to get

across to reading professionals because of the dogma associated with these cueing systems.

The many eye movement studies that we conduct show clearly that good readers basically survey every word on the page, even though it is counter-intuitive, because they are going so rapidly. On the other hand, poor reader's eyes gloss back and forth, trying to find any kind of anchor to predict a word they cannot get.

If we want children to decipher a code, we must teach them the appropriate strategies for doing so. It does not have anything to do with policies or philosophy. We have to teach children to understand the internal sound structure and how to map that onto print if we want them to be successful in deciphering a code in a rapid and fluent way. The amount of converging studies on these particular issues is great. To not utilize the data in a sense borders on malpractice.

Children have to learn to do sound extraction and phonics extraordinarily rapidly. It does not make any difference whether the children can sound out words or know phonemes. Simply put, the more time it takes to pull the print off the page, the less energy, cognitively speaking, a youngster has to incorporate what they just read into what they know.

Speed and fluency are equally necessary, but not sufficient, because we have to have children understand how to comprehend what they read. That does not come naturally, either. Many older readers that we have that are in the 99th percentile still do not know the difference between their point of view and the author's point of view. Many cannot articulate the strategies that might help them organize the information. Comprehension is critical. Sometimes we expect that to come along naturally as well. For many it might, but for many children the direct instruction of comprehension strategies is helpful.

A major predictor of difficulties in learning to read is the amount of experience children have in interacting with language and literacy. Children most at risk for poor reading are those who do not have a great deal of verbal interaction at home or who have not been read to. It puts them substantially at risk although their genetic predisposition and their neurobiology may be strong.

Multiple avenues can impinge on the developing system. Only a small number of the children we study seem to show departures from biologic and genetic typicality. The majority of children we see could learn to read quite well. It is just that we do not get to them early enough with the right interventions. If one learns to read and one does a lot of it, one reads better. If one does not reach children early, they do not learn to read very well. There are longitudinal studies that show this. Reading difficulty is not a developmental lag. These children do not catch up.

I want to conclude with some positive messages. If in fact we predict, which we can, children who are going to have difficulty learning to read and assign them to different kinds of teaching strategies and if we meld together these components that seem to be critical for early reading, the youngsters who are initially below the 10th percentile can read at the national average. So there is good news. If we can capitalize on what we know about what it takes to learn to read and get that to the children, they do maintain gains. If we do not get to them by 9 years of age with good informed teaching, then generally we have lost them as readers forever.

Carleatha Johnson: First let me say that my remarks come from my experience of working in an urban area in a large Head Start program. When I came to Head Start 25 years ago from a community organization, I had a very different view of what Head Start was and what Head Start should be. I viewed it as a preparation of the child for public school. However, that was not often the case. Extensive work had to be done for us to get on the same page in terms of purpose, that is preparing children and families for school.

When we talk about transition, there is a big problem because we all vary in our definition of transition. In Head Start, that means what we do in preparing the children for school differs. Some of us think of it as a process. Some of us think of it as a period of time. Some of us think of it as change. Some of us think of it as a bridge. I choose to think of it as a process with purpose. It is important that we understand what it is we are doing and why.

We need to understand that as children and their families enter our programs, we are talking about whom we are, what we do, and why we are here. If we are going to be bridges and if we are going to be about handing out or helping people with passports, we all have to know who it is we are and what it is we want to do. In trying to work this out within Head Start programs and in trying to work it out in the public schools, I found that the cultures of these two institutions are very different. They are very closed cultures. Head Start likes to talk about its openness, but we are closed about the purpose of what we are doing. So is the Department of Education. What we have not learned is how to develop the bridge between those two cultures and open a dialogue and keep it going. The culture of education is built on teaching children, and it is built, from a public school teacher's perspective, on how to develop children in terms of reading achievement, math achievement, and acquisition of knowledge. Head Start focuses on working with parents, social competence, and readiness skills.

In thinking of readiness, we also need to look at the culture of the family and the culture of the neighborhood or the community from which the child comes. We need to weave those into the relationships that we develop with the school. In Head Start, we wonder why parents hate to leave Head Start and why they hate to go into public school. We ignore the fact that, in a large part in Head Start, we are not clear about our purpose with parents from day one. It does not guide us in developing a relationship with them. So, instead of teaching them skills and connecting them to a role in public school from day one, we usually wait until April or May of each year to start talking about transition to the public school. That is not enough time.

The culture of the home and the neighborhood is very important. Two days ago in my program, a staff member coming to the Head Start center with her child and three other children from the neighborhood was shot and killed right in front of the center. The children witnessed this, and, of course, many children and staff from the center witnessed it as well. This is reflective of what is happening in the cities in terms of violence. It pervades our centers in ways that we do not even understand and it is a part of the children's culture. It is something that we have to consider when we are talking about what we are doing with children and families and how we are preparing them for school.

In working with the public school system, we also have to consider what is happening with schools and how it affects them. Maryland has focused extensively over the past 2 years on reading readiness. The whole language versus phonics argument is raging as we speak and confusing many of us who need to understand what that means for us in our Head Start programs.

In addition to trying to develop relationships with the public school, we also need to understand the pressures that schoolteachers face to get children to learn how to read. It does not help our relationship if Head Start is concentrating on social competence and the school is concentrating on reading readiness skills. I did not realize the meaning of this for me until I was confronted with enormous difficulty in trying to implement, over the past 3 years, a language enhancement program in our program.

Head Start has grown very complex over the past 25 years. Some of us understand that; some of us do not. All of us need to be brought along on the same road, looking at the same things. In conclusion, my message is that we have to agree about what we mean by transition and continuity. We need to agree on our role from a Head Start point of view in assisting families in making this bridge from Head Start to the public school.

Rita Moore: My Head Start experience offered me an opportunity to learn and work on behalf of children and families. As a parent in the program, I volunteered in classrooms, attended numerous training sessions, conducted workshops, and participated in parent and community activities. I learned about child development, education, healthy living, and community advocacy. I participate on policy committees, policy councils, and governing boards at the local, state, and regional level. I would like to share my experience that I believe helped me and my

children transition into the public schools. You might consider my experience an insider's view because my Head Start program belonged to a school system. It was an interesting process. I am going to share two examples of parent involvement that focus on what I feel are the most important elements of advocacy: assertiveness and persistence.

I recently participated in the national demonstration project, the Head Start Public School Transition Project, in Fairfax County. The research project followed Head Start children and families from kindergarten through third grade. At one point, I had one child in Head Start and one in the Transition project. Both were receiving the same type of services, but the feeling was different. For example, from day one in Head Start, I was invited, encouraged, and pushed to join my child in the classroom. On day one of kindergarten, I was given instructions on when to visit my child and what to do during that visit. Head Start parents, myself included, thought our children were singled out and labeled as behavior problems because of the play-based learning curriculum used by Head Start.

Our program responded to our concerns by providing training to the school staff about Head Start, selected Head Start parents as trainers, and set up school-based meetings with the school, with parents being members. Other activities helped school staff and parents work more closely together, including having home visits. I even had the principal come to my house. Social events and school employees in the role of parent liaisons also helped.

My next example is about authority and decision-making. In Head Start, we were given the opportunity to approve, recommend, and be advisers to all aspects of the program while working with the Parent Policy Council and the Transition Governing Board. With the PTA, it was very different. It was different because in Head Start I was approving and hiring staff and for the school, I was selling candy and organizing family socials. I somehow thought one would be an extension of the other. However, I realized that my role had changed and accepted my responsibility in helping my school.

I continue to be assertive and persistent. I go to PTA meetings. I volunteer in the classroom. I work with the parent liaison and the staff in the school. I continue to work with Head Start and take every opportunity to expound my Head Start philosophy. Head Start has helped me in different ways to be involved with my children's education. I continue to figure out ways to stay involved as my children continue to move through the public school system.

My message to Head Start is to continue to work with families to prepare them for the public school system, because it is still a challenge once you walk in the door. To public schools, I advise you to continue to develop partnerships with the parents in Head Start to continue the foundation that Head Start has laid. To researchers, make sure you understand what families are saying.

I am going to relay a story about one of my children. My boy is now in the sixth grade. When he started Head Start, he had a learning disability. His Head Start teacher came to let me know about it and we worked together. He left the school system. He was even labeled mildly retarded. After working with a Head Start teacher within the program, we brought him back into the public school system and now he is an "A" student. He also has talked in front of our Fairfax County School Board.

Grover Whitehurst: I am going to take a contrary point of view about something that is equivalent in developmental psychology to motherhood and apple pie. That is the notion of readiness and developmental continuity. The notion is that as the twig is bent so grows the tree. I believe that too. However, I want to suggest that there are some wrinkles in the readiness story that we need to pay attention to if we are going to do the good work we all want to do for children.

The work that I will be talking to you about is done in the context of a longitudinal study I have been conducting with a population of Head Start children from Long Island, New York. We have followed them in three cohorts since about 1992 when there were about 400 children. It has

been a tremendous opportunity for me to be involved initially with Head Start centers and with the families and subsequently with the children as they progressed through elementary school.

Some common readiness assumptions include that (a) many children enter school unprepared to learn, (b) schools cannot be expected to succeed with unprepared children, and (c) Head Start, children's families, and somehow the culture is to blame if the children do not do well or if the effects of early intervention fade out.

When one looks at the research that relates to these assumptions, one finds that it is not as clear as it might be. For example, evaluations of early intervention programs always confound the early intervention programs with the nature of the schools and the communities in which these interventions exist. If effects fade out, is that because Head Start did not do its job or the early intervention program did not do its job, or does it have something to do with the schools into which the Head Start children or the early intervention children transition? It is very hard to tell which of those might be the case. Of course, it might be both of those things or other things as well.

I want to talk about several variables that represent these wrinkles in readiness, beginning with age. Both in general populations of children and in Head Start children as well, chronological age is strongly associated with readiness skills. For example, the oldest children in a class of 4-year-olds in Head Start will typically be doing better on emergent literacy skills than the youngest children in the class. If readiness is the determinant of academic success, then the oldest children in a Head Start group should do better in school than the youngest, and children who are a year apart in schooling but close in age should have similar academic skills.

Thus, if you have two children living next door to each other, and one of them is born on November 25th and one of them is born December 5th, but because of the cutoff date in school, one is in first grade and one is in kindergarten, we should see effects related to readiness.

Figure 1-1
Effects of Age Within Grades

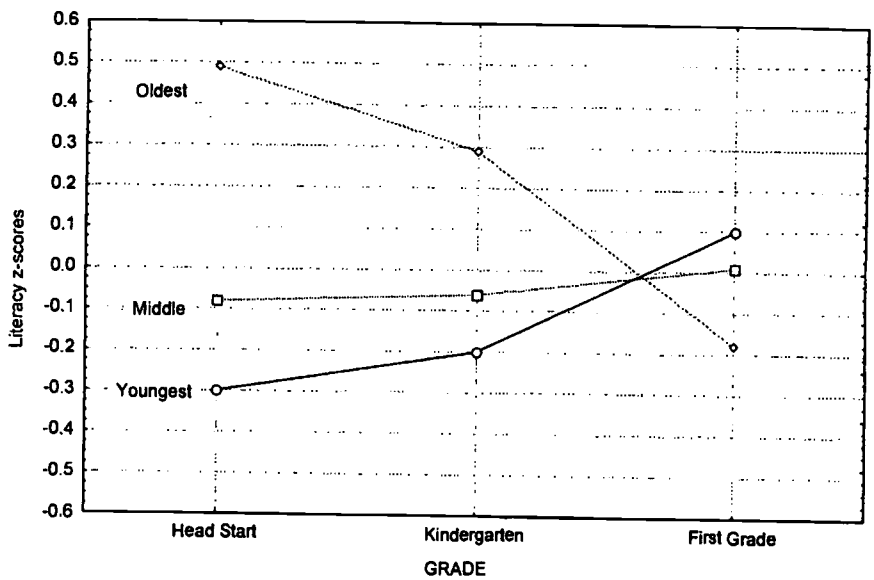


Figure 1-1 illustrates a division of cohorts of Head Start children. It shows the differences among the oldest children in a particular cohort (children who are within 2 months of the cutoff date), children who are in the middle of the age group, and children who are the youngest in the age group in particular years of Head Start. We followed these children through

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elementary school, and the graph demonstrates results through the end of first grade.

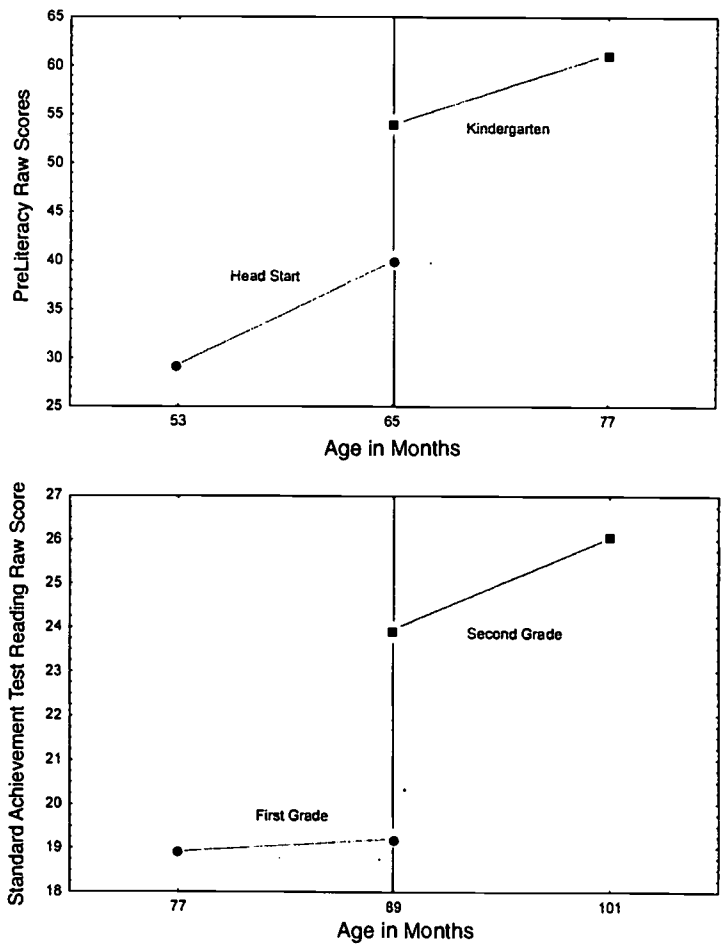
We measured emergent literacy skills such as knowledge of the alphabet, phonemic awareness, knowledge of print, knowledge of the front and back of the book, and print versus picture on the page, which are items that we know are clear predictors of literacy success in school.

During Head Start there is almost a standard deviation of difference between the oldest children in the class and the youngest children in the class, with the oldest knowing much more about these things than the youngest. The oldest children are clearly more ready for school instruction than the youngest children, by a wide gap. Yet by the end of first grade, these two lines have come together and now we are measuring actual reading performance, word attack, and word reading. Large differences in readiness have been erased by the school experience at the end of the first year. It is a wrinkle, and it is something that needs to be thought about when we are committed to the notion that readiness is all-important.

In another example, we look at two boys, Jimmy and Johnny, who live next door to each other and who are almost the same age, but ended up, because of the school cutoff, in different grades. When the line in Figure 1-2 crosses in the middle, these are children who are the same age, but differ by a grade in their academic experience because of the grade cutoff. There is a huge gap in how they are doing, despite equivalence in terms of readiness.

One of these graphs depicts performance in the Head Start to kindergarten transition and the other depicts the first grade to second grade transition. In both cases, the children who are

Figure 1-2
Effects of Grades Within Age



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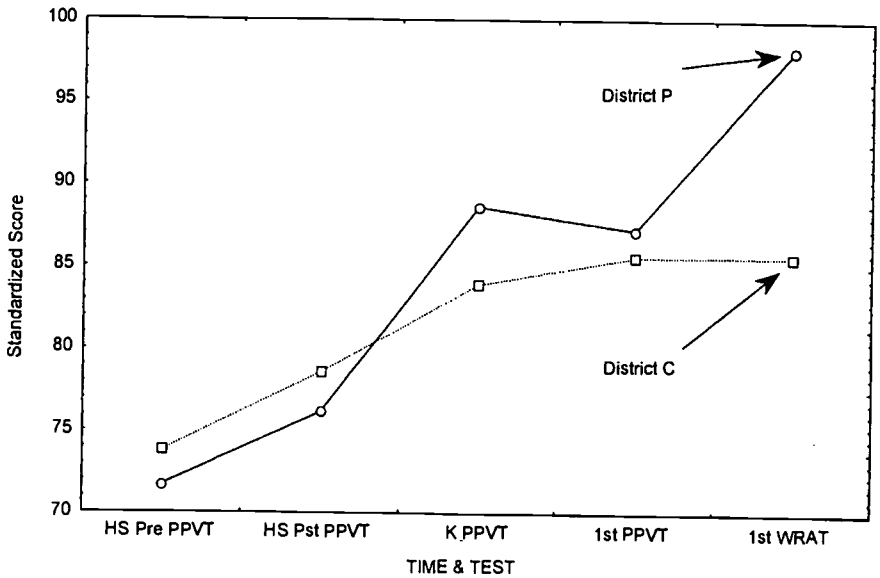
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practically the same age and have the same backgrounds are performing at vastly different levels if they happen to fall on the opposite sides of the grade cutoff. Children who are in the older grade are doing better than children in the younger grade.

To the extent that children's readiness skills are all-powerful determinants of academic success, children with similar levels of readiness should achieve similar outcomes regardless of variation across schools. We have done extensive research on this, but I think it is easiest to illustrate it with a tale of two districts.

Figure 1-3 shows two groups of Head Start children. They have attended the same Head Start program. They have statistically identical backgrounds in terms of family characteristics and racial ethnic makeup. In fact, they start at the same level in terms of their skills. In District C, children show a gradually rising curve that is consistent from Head Start through the end of first grade, with the final performance being literacy performance. District C is a fairly disorganized district.

Figure 1-3
A Tale of Two Districts



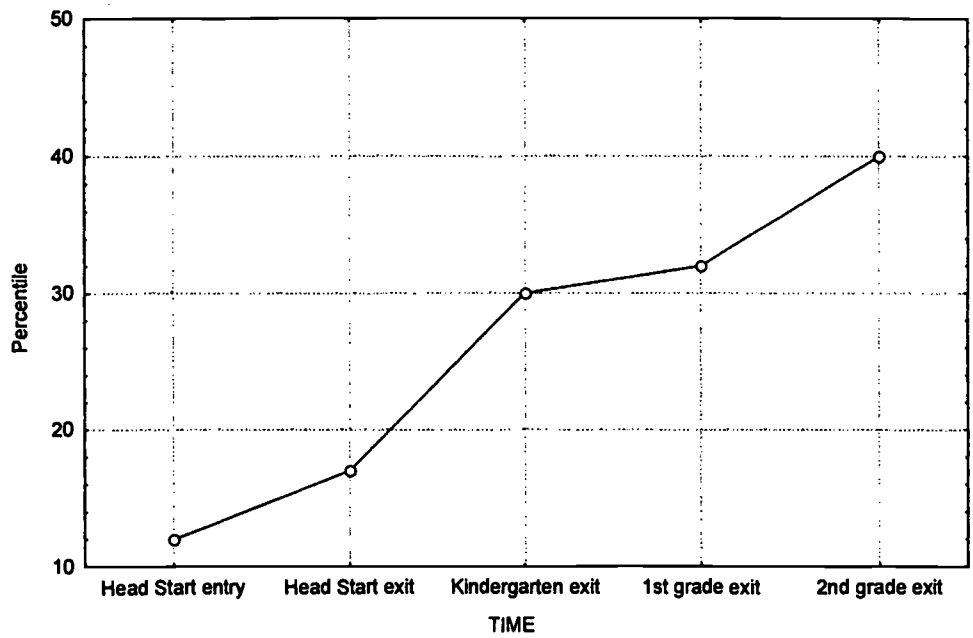
In District P, the children have the same early trajectory. However, they move into an excellent school district. At this point, the two curves diverge dramatically, with the children in the better district doing dramatically better on reading performance at the end of first grade than children in the poorer district read. Once again, there is a situation where children enter school with the same level of readiness, but they differ dramatically after 1 year, based on the quality of the district.

To the degree that readiness is all powerful, children with lower levels of readiness should experience deceleration in academic performance. They should fall further and further behind compared to children with a high level of readiness across time. Figure 1-4 illustrates the normative outcomes for our sample of roughly 400 children followed from the time they entered Head Start as 4-year-olds. The graph shows percentile scores on standardized assessment instruments. These children enter Head Start at about the 12th percentile in terms of their language and readiness skills. They exit at about the 16th percentile, which is a very low level of readiness. However, across time their progress is continuously accelerating. By the time these children exit second grade, they are at the 40th percentile in terms of reading performance.

These findings are in the context of the Long Island school districts that typically are very

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Figure 1-4
Normative Outcomes



good. The average teacher's salary is almost twice the national average, and the expenditure per child is about $13,000 a year compared to the national average of $6,000. These children, given where they started, are doing amazingly well in terms of reading at the end of second grade.

In conclusion, readiness is important, but it should not blind us to the extremely powerful effects of schools on children's development. Children can be taught to read despite low levels of readiness. Reading does not have a critical period associated with it. Adults can move to this country completely illiterate and be taught to read fluently within 2 years. We should ask no less of school systems when they encounter children in kindergarten or in grade one. Head Start should not be expected to inoculate children against the effects of bad schools and bad instruction. Readiness is important, but it is not all-important. We should remind school systems that children are coming, ready or not.

David Denton: The Southern Regional Education Board (SREB) has been working on the readiness goal ever since we established our own regional goal in 1988. Early on, we established as a principle that readiness had to have two sides. It is one thing to help children to get ready for school. Everything we can do to help children be more prepared for school is wonderful. At the same time, we have to hold our schools responsible for doing the absolute best job they can with all children.

I think that reading crosses the issue of the two sides of readiness very well. It has been complicated in many ways recently. The NICHD research is very clear on phonemic awareness, has been characterized by the highest scientific standards, and has provided invaluable knowledge about how good readers read and why many children do not become good readers.

The research has clearly shown us that phonemic awareness, the knowledge that certain letters and letter combinations correspond to certain sounds, is a critically important skill that all good readers must master. Unfortunately, the reading wars have been dominated by a few strident voices coming from the opposite poles of the debate.

On the one hand, there are those who insist in repudiation of the preponderance of evidence,

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that any direct instruction in phonemic awareness at all is too much for any child. At the opposite pole are those who insist that phonics is by itself the only valid approach to teaching reading.

The NICHD research, while establishing the importance of phonemic awareness, has also validated many of the most basic tenets of the reading philosophy known as whole language. It is clear from the research that the best reading programs provide many opportunities for children to read a wide variety of good literature. There is nothing in the research that supports the idea that a program based exclusively on skills instruction with little emphasis on reading for meaning and pleasure is an appropriate way to teach children. Children must master the necessary skills, but they must also be engaged and given reasons for wanting to read.

Unfortunately, many early childhood people have been suspicious of the research on phonemic awareness. There tends to be a reaction that direct instruction cannot possibly be developmentally appropriate at any level in early childhood. Thus, a school providing direct instruction related to phonemic awareness must not be ready for children. My question would be, why not?

Fundamental to the principles of developmental appropriateness from kindergarten through twelfth grade is that children do need a bit more structure as they go along. They need more specific kinds of learning activities than they had in earlier developmental stages when they are trying to develop some of the bases for later knowledge. In fact, phonemic awareness is just one basic skill that has to be taught if children are going to learn to read. It does not invalidate other ideas of developmental appropriateness and it does not mean that direct instruction in everything is necessary. It means we must ensure that children have phonemic awareness in place by third grade at the latest.

Those in the early childhood community who have looked closely at the NICHD research clearly recognize this. High Scope recently endorsed it in their newsletter. Recently, NAEYC printed their joint statement on literacy development with the International Reading Association. Sue Bredekamp was one of the people involved in this, and there is no one more committed to developmental appropriateness than Sue. There are a couple of relevant quotes from that statement: (a) There is accumulative evidence that instructing children in phonemic awareness in kindergarten and first grade enhances reading achievement; and (b) Phonemic awareness is not merely a solitary insight or an instant ability. It takes time and practice.

It is important to recognize that the schools that are attending to phonemic awareness, that are assessing children to determine their needs and then providing direct instruction in phonemic awareness to the children who need it, are schools that are ready for all children. A school that overdoes phonics at the expense of reading for meaning, especially for those children who already have a good grasp of phonemic awareness, is not any more ready than a school that is not addressing phonemic awareness at all.

There has been misinterpretation of the research on phonemic awareness. Some of it, I am afraid, is willful, but much is just wishful thinking. On one hand, there are those who simply cannot accept the idea of developmental appropriateness at all and who want education at all levels to be extraordinarily structured. They want the research to validate their position, but it does not. On the other hand, there are those who advocate whole language and who do not want to believe that direct instruction in phonemic awareness is appropriate. However, the evidence does not support them either. We cannot ignore sound research findings because we do not like the results.

We have to be willing to learn as we go along, and we have to be willing to recognize that the state of the art today is not going to be the same as the state of the art tomorrow. We cannot wait for tomorrow to do anything; we have to act today the best we can on the best knowledge we have. At the same time, we have to be ready to make changes on the basis of what we learn tomorrow.

Effective transitions require understanding in both directions. Early childhood people must recognize that schools are doing the right thing if they do phonemic awareness in a balanced

reading program that tailors instruction to individual children. We need to make schools understand what developmental appropriateness means for preschool children and how to deal with the children who come to them both prepared and unprepared. We all have to recognize that there are different kinds of preparedness. Different children are going to have different areas where they need particular help. Children are different.

I have been in a number of schools in the South where this is clearly understood and instruction is tailored to meet the needs of different children. However, we are still fighting the cookie-cutter mentality in many schools. The desire of policy makers in particular and of some administrators to be able to settle on one program that will work for everyone will not happen.

I do believe, however, that as schools begin to put the reading research findings into practice, recognizing what balance means and recognizing the differences in the types of instruction different children need, it can help them develop a better overall understanding of the concept of developmental appropriateness. In general, it should help make transitions much smoother between all preschool programs and elementary schools.

AUDIENCE COMMENTS

Comment: I am interested in the preschool population based on what was said in terms of phonemic awareness. I am thinking in particular of the Ramey research. Even in a very intensive research study where language acquisition was the focus, they still looked at children who, when they entered school, were depressed in terms of the number of words they understood and used. I would like some information from the panel about the kinds of programs for the preschool population that they would highlight for our consideration.

Reid Lyon: One of the things I say constantly was we started at age 5, which is not early enough. The reason we do not start earlier is practical. It is very hard to measure young children in a reliable way. We are developing measures for 2-year-olds and beyond now, but our research is not that informative. What we know is that in the individual difference work that we do, many 4-year-olds are picking up some of the foundational elements of reading, but clearly, many are not. The programs that may address these kinds of skills are unknown to me and I do not know which ones help at that age level. I do know that Marilyn Adams, Barbara Foreman, and others have developed a very practical research-based program for developing critical linguistic skills in children, I believe, for 4½ years old and beyond. NIH does not sell these programs, I am just aware of them.

The issue in teaching is to present all of this in a way in which the youngsters enjoy. If we use terms like phoneme awareness or phonics or speed and automaticity or comprehension, it does not mean that children are overwhelmed with direct instruction. It means that they are all meshed together in a vibrant, meaningful way.

David Dickinson: I have been conducting a longitudinal study for 10 years with Catherine Snow, starting when children were 3 years old, and focusing on language and literacy development. We have data on 3- and 4-year-old children.

I would like to make a couple of comments related to how some of these things can be implemented in classrooms. There are some myths that I have seen as I have talked with preschool teachers and directors. First of all, the alphabet is not a bad thing. There is a fear that anytime you start to think about literacy it means worksheets. Too many teachers in Head Start have seen the misuse and the misunderstanding of developmentally appropriate ways of getting children involved in early literacy. Understanding the alphabet is one piece of knowledge that is very concrete.

Secondly, children like to write. If you give them space to write and things to write with, they will do it. Our study shows that this is a good predictor of later reading and phonemic aware-

ness. Children also like to read books with teachers individually. Teachers do not do this much from what I have seen, even though it is very appropriate.

Comment: When Head Start quality money came to us a few years ago, we developed a language enhancement project. What we found among many children was an inability to express themselves. Some children come from families without a lot of expressive language. Sometimes staff reflect that. We were trying to encourage that kind of conversation among children and staff to model for families.

We also put, through the assistance of a foundation, at least 80 books in every classroom. We put them in classrooms as lending libraries that could be utilized by parents. We put them in classrooms because we wanted children to see their parents coming in to borrow these books. The foundation also enabled us to buy four books that the children took home permanently, as well as writing kits. The children loved them and assisted us in working with parents.

Comment: What is missing in this conversation is the notion that many of our children are speaking a different language at home. I would like the panel to address the issue of what we do when the child has a very different phoneme structure. What are the implications of English as a second language in terms of reading and writing?

Lyon: At Harvard, Catherine Snow and her research team have been studying this particular issue. In addition, we are preparing to initiate a large project that addresses Spanish to English literacy and we are working with the Department of Education in that context. Some of the questions that we were considering were: (a) Do youngsters learn to read more efficiently and comprehend better in English if they first learn to read in their native language, Spanish? and (b) Do youngsters, who are immersed into English, whether or not they have any modicum of capability in that area, learn to read better?

It struck us that all the languages, but I will talk about Spanish now, differ in this country on a wide variety of dimensions. The Spanish spoken in Brownsville is not the same Spanish spoken in Brooklyn. In our brief surveys to get ready for the initiative, we found that many Spanish-speaking homes varied in their support for literacy activities in Spanish or English. That is, children go from their academic setting back to a home which varies dramatically in the kind of language that is used associated with literacy. There are many combinations of Spanish used in the home that are not used in school.

We have numerous factors that we have to address descriptively. Additionally, we have to develop measures to address these questions. There is a lot of good, ethnographic, observational, descriptive work coming from a wide variety of sources, but we were premature in asking these kinds of instructional questions before we even knew the lay of the land. The initiative continues to move forward, but it is moving forward with a greater degree of reality. We are visiting programs throughout the country that work with Spanish-speaking youngsters who have to make multiple transitions.

Plenary II

Immigration and Migration and Its Effects on Children and Their Communities

CO-CHAIRS: John M. Pascoe, Gloria Johnson-Powell
PRESENTERS: Donald J. Hernandez, Cynthia Garcia Coll, Howard Markel
DISCUSSANT: Heike Thiel de Bocanegra

- **Family and Economic Circumstances of Children in Immigrant and Nonimmigrant Families: 1910–1990**
  Donald J. Hernandez
- **Children of Immigrants: School, Self, and Community**
  Cynthia Garcia Coll
- **Caring for the Foreign-Born: The Health of Immigrant Children in the United States, 1890–1925**
  Howard Markel

John M. Pascoe: From 1980 to 1995, there was a surge of migration to the United States. This population movement dramatically impacted both the health care system and the education system. Because many immigrants speak little or no English, educators and physicians have faced new challenges to provide excellent schooling and medical care to immigrant children and their families. This plenary session examines the socioeconomic risk factors of migration in the 20th century and the impact of immigration and migration on childhood developmental processes and child health.

Donald Hernandez: Today's children are the parents, workers, and citizens of the future. No group of children in the United States is expanding more rapidly than children in immigrant families. From 1990 to 1997 the number of children with at least one foreign-born parent grew by 47%, compared to only 7% growth for children with native-born parents.

In 1997, one of every five children in the U.S. was the child of an immigrant. During the next three decades, most future growth in the number of children in the U.S. will occur through immigration and births to immigrants and their children. Because the majority of children in immigrant families are of Hispanic or Asian origin, the proportion of children in the U.S. who are non-Hispanic Whites is projected to drop from 69% in 1990 to 51% in 2030.

Only 32 years from today, the proportion of children who are Hispanic, African American, Asian, or of another non-White race will expand from 31% to 49%. During the same decades, as

the Baby Boom Generation reaches retirement age, the vast majority of the elderly will be non-Hispanic Whites. As such, for economic support they will depend increasingly on the productivity, health, and civic participation of adults who grew up as first or second-generation children in minority immigrant families.

In this context the recent reforms to the U.S. social welfare system take on special meaning. The extremely restrictive eligibility rules for many programs that applied historically only to illegal immigrants are now also applied to legal immigrants. Moreover, the authority for decisions regarding eligibility has been shifted from the federal government to the individual state governments.

The research that I will summarize today provides an historical perspective for the United States on socioeconomic and demographic risk factors experienced by children in immigrant families compared to those in native-born families. This research represents the first time that decennial census data have been used with children as the unit of analysis to study long-term historical changes in the lives of children in immigrant and native-born families. The research is part of a much larger project which will lead, during the coming months, to a new National Academy of Sciences and Institute of Medicine report on the health and adjustment of immigrant children and families.

Children in immigrant families are defined as either first generation children who were born in a foreign country, or second generation children who were born in the U.S. but have at least one foreign-born parent. Children in native-born families are defined as third and later generation children who are U.S.-born children with U.S.-born parents.

Before I turn to these results I would like to briefly mention that immigration to other developed countries in Europe and elsewhere in the world is parallel to the situation in the U.S. in three critical ways. First, fertility rates of native-born populations are at the population replacement level or less, and the white majority population in these countries is rapidly aging. Second, immigration from third world countries is leading to rapid growth in the minority immigrant population of receiving countries. Third, social welfare policies that apply to minority foreign-born populations are being seriously reevaluated by many of those national governments. Clearly, the opportunity and need for international comparative research exists. Such research might examine the influence of public policy on the well-being and development of children both in immigrant and native-born families.

In the United States, immigrants from various countries of origin may differ enormously in their socioeconomic and demographic characteristics, their language and culture, and their racial and ethnic composition. The number and origins of children in immigrant families in the U.S. have changed greatly during the 20th century. As a proportion of all children, children in immigrant families plummeted from 28% in 1910 to only 6% in 1960. Since then the proportion has expanded to 13% in 1990, and in 1997 it was 20%. That is a level about two-thirds as high as at the turn of the century.

As of 1910, nearly all children in immigrant families in the US had origins in Europe or Canada. In 1990 one-half of children in immigrant families had origins in Latin America and one fourth had roots in Asia. Mexico has become an especially important source of immigrants. In 1990, one third of all children in immigrant families had ancestral links to Mexico.

The extent to which the risks and needs of children in immigrant families and children in native-born families differ, depends in part on the extent to which family circumstances are similar or different. Factors that have been found to have negative consequences for children in general include: poverty, low parental educational attainments, limited paid work by various family members, living in a one-parent family and/or with a large number of siblings, and exposure to overcrowded housing conditions.

The official poverty rate for children in immigrant families in the 1960 census was less than that of native-born families. However, by 1990 the situation had reversed—the poverty rate for children in immigrant families (22%) was somewhat higher than the poverty rate for children in

native-born families (17%). Most of the difference is accounted for by a very high poverty rate (33%) among first generation children in 1990. Underlying these overall statistics, however, the enormous differences among children in immigrant families varies according to country of origin and among children in native families belonging to various racial and ethnic groups.

The poverty rate for children in native-born families in the 1990 census ranged from a low of only 11% for non-Hispanic Whites to 17% for non-Hispanic Asians, 28% for Hispanics, 35% for American Indians, and 40% for African Americans.

For different countries of origin, poverty rates of children in immigrant families range from a low of only 4% for children with origins in Ireland, to a high of 51% for children with origins in Laos. Altogether, children with origins in approximately two dozen countries spread across Latin America and the Caribbean, Asia, Europe, the Middle East, and Africa had poverty rates that were about equal to or actually less than the 11% rate for non-Hispanic White children in native-born families. However, at the other extreme, children in immigrant families with origins in twelve other countries had poverty rates that were quite high, ranging from 26% to 51%. That is in the range experienced by Hispanic, African American, and American Indian children in native-born families.

In view of the negative risks associated with poverty, the situation of children from 12 countries is of particular concern. Five of these countries are the source of many officially recognized refugees: the former Soviet Union, Cambodia, Laos, Thailand, and Vietnam. Three are war-torn countries in Central America: El Salvador, Nicaragua, and Guatemala. Three are small, impoverished Central American or Caribbean countries that are sources of unskilled labor migrants: Honduras, Haiti, and the Dominican Republic. The twelfth country is Mexico, which currently sends the largest number of both legal and illegal unskilled labor immigrants, and which has been a source of unskilled labor for the U.S. economy throughout the 20th century.

Within the racial and ethnic stratification system of the U.S., most children from 11 of these 12 countries are classified as Hispanic, Asian, or Black. The sole exception is the former Soviet Union. Children in immigrant families with origins in these 12 countries accounted for about one half of all children in immigrant families in the 1990 census, but they accounted for three fourths of the children in immigrant families who lived in poverty. Mexico alone accounted for nearly one third of all children in immigrant families, but about one half of those officially classified as poor in the 1990 census.

Turning to parents' education, children in immigrant and native-born families were about equally likely to have fathers who had graduated from college and to have mothers who had graduated from college. Children in immigrant families overall were also much more likely than children in native-born families to have parents with extremely low educational attainments.

For example, the proportion of first and second generation children in 1990 who had fathers with no more than 8 years of schooling was 34% and 23% respectively for the two generations, compared to only 4% for children in native-born families. The proportions were especially high for most of the 12 countries with very high poverty rates. A similar pattern was observed for mothers' educational attainments in 1990.

Earlier in the century, differences in proportions of low parental educational attainments between children in immigrant and native-born families were substantially smaller. However, throughout the century, African American-, American Indian-, and Mexican-origin children in native-born families had been much more likely than non-Hispanic Whites in native-born families to have fathers with very low educational attainments.

Regarding parental labor force participation, throughout the century the overwhelming majority of first, second, third, and later generation children with fathers in the home had fathers who worked in the labor force. Despite high levels of employment among fathers in the homes of children in immigrant families, many children lived with fathers who worked less than fulltime year-round in 1990. Estimates by country of origin show that this was true for children in immigrant families from most specific countries of origin, but especially for those

with the highest child poverty rates. It is the lack of full-time, year-round employment among fathers in the home, along with very low fathers' educational attainments and linguistic isolation from English-speaking culture that is especially common among children from the 12 countries of origin with very high poverty rates.

Turning to one-parent families, in 1910 and in 1960, children in immigrant and native-born families were about equally likely to live in a one-parent family. By 1990, however, 26% of children in native-born families lived with one parent, notably more than the 17% of children in immigrant families who lived with only one parent. The proportion of children living in large families with five or more siblings has dropped dramatically during this century for children in both immigrant and native-born families. By 1990, children in immigrant families were somewhat more likely than children in native-born families to have a large number of siblings, especially among foreign-born children.

Among children in immigrant families from the 12 countries of origin with very high poverty rates, children with origins in 8 of these countries experienced either a high proportion in one-parent families or a high proportion with a large number of siblings, but not both. In contrast, children with origins in three of these countries experienced high proportions on both risk factors.

Children in immigrant families were less likely than children in native-born families to live in overcrowded housing in 1960, but enormously more likely to live in overcrowded housing in 1990. Children in immigrant families from the 12 countries with very high poverty rates were especially likely to live in overcrowded housing in 1990. Children in native-born families of Mexican origin also experienced an extraordinary level of overcrowding in 1990, at 31%, similar to the 26% and 33% experienced respectively by African American and American Indian children. These proportions were enormously greater than the 7% experienced by non-Hispanic White children in native-born families.

Beyond these general risk factors, children in immigrant families may be at special risk because of circumstances associated specifically with immigration. A lack of English fluency can limit effective communication and functioning in health care facilities, schools, and other settings that provide resources to children and families. First generation (55%) and second-generation (81%) children in immigrant families speak English exclusively or very well. These proportions are, however, substantially lower for children from the 12 countries of origin who experienced very high poverty rates.

Moving beyond the language skills of children to the language skills of all persons in their households, the Census Bureau defines a linguistically isolated household as one in which no person age 14 or over speaks English either exclusively or very well. Among children in immigrant families in 1990, 26% lived in linguistically isolated households. However, among children from each of the 12 countries of origin with high levels of poverty, the proportions in linguistically isolated households were much higher, reaching a peak of 60% for Laos and Cambodia. Available data for 1910 suggests, however, that there was little change during the century in the overall proportion of children in immigrant families living with parents who did not speak English.

Children who are undocumented are not eligible for most public services and benefits, and under the new Welfare Reform law, children who are legal immigrants but not citizens may also not be eligible for important medical and social services. Equally important, native-born children in immigrant families who are eligible for such services may not receive them because immigrant parents who are not themselves eligible for services may not be aware that their children are eligible, or these parents may fear contact with government agencies administering the services.

As legal immigrants and children experience essentially the same welfare eligibility requirements prior to welfare reform, non-U.S. citizenship has only recently become a potential risk factor for legal immigrant children and families. By 1990, only 21% of children in immigrant

families were not citizens, but approximately two thirds were either themselves not citizens or lived with a non-citizen parent. This proportion rose to about 75% or more for children in immigrant families with origins in 10 of the 12 countries with high poverty rates. The figure was 50% or more for 18 of the other 26 countries of origin with child poverty rates at least as high as non-Hispanic Whites in native-born families.

Thus, children in immigrant families from countries of origin with high poverty rates often are not citizens or have at least one parent who is not a citizen. The devolution of responsibilities under welfare reform from the federal government to state governments also implies that eligibility for and access to publicly funded health, medical, and social services by children in immigrant families will depend increasingly on decisions by state and local governments. Because 74% of children in immigrant families live in six states with the highest proportions of children in immigrant families, decisions about welfare reform in these states will be critical for many children in immigrant families.

In summary, children in immigrant families in 1990 were less likely than children in native-born families to have only one parent in the home. In contrast, they were more likely to: live with two parents, live in poverty, have a large number of siblings, have parents who had not finished school beyond the eighth grade, and live in overcrowded housing conditions. Children in immigrant families were similar to children in native-born families with fathers in the home in having a father who was in the labor force. Immigrant fathers work, but are less likely to find full-time, year-round work.

The socioeconomic and demographic risk factors experienced by children in immigrant families vary enormously from country to country. Of particular concern are the potential risks experienced by immigrant children from 12 countries with very high poverty rates. These children experience socioeconomic and demographic risks in the range experienced by children in native-born families who are African American, Hispanic, and American Indian. The proportion of children exposed to important socioeconomic and demographic risk factors do decline between the first and the second generation for children from most of the 12 countries of origin with high poverty rates.

Data suggests that among children in native-born families with origins in Mexico, the Dominican Republic, and Central America, the proportion living in poverty with parents who are not high school graduates, who live in overcrowded housing, or have only one parent in the home remain quite high. In addition, throughout the century, Mexican-origin children, like African American and American Indian children, have been among those with high proportions exposed to elevated socioeconomic and demographic risks.

The vast majority of children in immigrant families speak a language other than English at home, but the vast majority of them speak English at least very well. Language assimilation occurs rapidly across generations.

With the passage of welfare reform, lack of U.S. citizenship became a potentially important risk factor for legal immigrants by limiting eligibility and access of these non-citizens to public benefits and services. A large majority of children in immigrant families may not be eligible for important benefits, or they have parents who are not eligible for important benefits. Reductions in benefits available to such families will reduce economic resources available to these families and children.

I would like to leave you with two questions for our national research agenda that are critical to the future of the U.S. and the non-Hispanic White majority of the Baby Boom generation. First, to what extent will children in immigrant families today grow up to become productive, healthy, and effective citizens? Second, to what extent will federal and state social welfare policies help or hinder the development of these children?

Cynthia Garcia Coll: I was studying developmental processes in minority families, and began to observe that comparisons between children of immigrants, recent immigrants, and native-

born minority children are made in terms of economic status. Data, like that just presented by Don Hernandez, has a great deal of information missing regarding the child's experience. Process-oriented research is one way to examine how children make sense of themselves, media messages, teachers, administrators, police officers, and their parents. Each offers a child very mixed messages regarding their value, goals, and potential.

For the last year-and-a-half, as part of the McArthur Network on Successful Pathways Through Middle Childhood, my colleagues and I have been conducting research in Providence, Rhode Island, New York City, Philadelphia, and am now starting to work in North Carolina. Our guiding research questions are:

1) What are the range of racial/ethnic identities to which immigrant and native-born children relate?
2) Given multiple identities, what are children's constructions and expression of their racial/ethnic identities?
3) How do children feel about their own gender, ethnicity, race, and immigration status? Would that vary in different contexts?
4) What are the experiences of racism and discrimination among children?
5) How do these issues relate to children's engagement with institutions, such as school and after school activities, including homework?
6) Are developmental processes related to immigrant status, race/ethnicity, and children's age?

Today, I will present four children from the study, as well as data on 154 children from the public school system in Providence with whom we conducted 2-hour interviews. Seventy-one percent of the sample are from immigrant families and 23% were born in the United States. Eighty-three percent are below the poverty level. In addition to the interviews, we have led focus groups with 9- to 12-year-olds about school, spoke with teachers and administrators in the Providence public school system, and conducted 16 intensive case studies following these children during waking hours for 5 days to determine their routines and get a sense of their lives. A larger future study will examine the continuity of experience between children of color whose parents were bom in the US, and children of color whose parents were born in other countries.

We plan to continue work in the field for another 3 years with 1,200 children. Based on the preliminary data, the study's major findings to date are as follows. First, children have multiple and overlapping components to their personal, ethnic, national, and racial identities. Second, they are able to prioritize them in order of significance to their personal identities. We found that when given a choice of more than one label to describe themselves, they elaborate about many different identities.

Kim describes herself with the following labels. She is a girl foremost, because her gender is very important. Second, she is Cambodian, because her family was born in Cambodia. Third, she is a Buddhist. Fourth, as one of the little ones in her family, she is also a child. Fifth, she is Asian too, because that is the way that her family is perceived. Finally, she knows that she is Asian American because she was born in this country. The notion of American is linked to birth more than anything else.

Juan is a child and a boy foremost. Second, he is Dominican American because his parents are from the Dominican Republic. Third, he is also White. He is very clear that he is light-skinned and sees that as very relevant. Finally he is Dominican and American. Jennifer is a White native-born girl. She labels herself as a girl, a child, White, and American.

When asked "what do you think you are," David, a 6-year-old, said that he is American because he speaks American (English). Second, he is Indian because his parents are Indian and his mother is teaching him the Indian language. Third, he is Black because his skin is a little black. Finally, he is Japanese because he is learning the Japanese language. Clearly, these notions of ethnic identities are very fluid, but language is a major component.

The construction of multiple racial and ethnic identities are based primarily on parents' place

of origin (29.3%), their own place of origin (16.6%), language (13.4%), and skin color (10.2%). Racial/ethnic identities are seldom based primarily on cultural activities (0.6%) or current location of residence (3.9%). Children feel connected to their parents' country of origin.

Immigrant children were more likely to define themselves in terms of roles (39%) compared to their non-immigrant counterparts, who were instead likely to use physical characteristics (29%). An immigrant boy might describe himself as the youngest child in his family, while a non-immigrant might define herself by her black hair.

In addition, younger children tended to use role descriptors (41%) while older children used personality descriptors (32%). Latino children were more likely than others to deny stereotypes (51%), while others rarely mentioned them. For example, when asked "what are you not?" Latino children might say they are not lazy. From the age of 6, there is the knowledge of what stereotypes exist and what the child would like to counteract.

Asians, Whites, and African Americans select gender as their first descriptor, while Latinos define themselves in terms of their ethnicity. Ethnicity is part of a child's identity from a very early age. Children's affective reactions to their own race and ethnicity differ from context to context. Overall, all children were pleased with their own race and ethnicity, especially within the family context. For example, when children talk about their skin colors, they feel good about having the same color skin as their mother or father.

When asked about their racial and ethnic backgrounds in the context of peer relations, children's responses were largely positive except with peers from backgrounds different from their own. Many of the children felt that they were mistreated by their peers. The sense of exclusion and discrimination that children have is perceived as coming from their peers. For example, Jennifer feels positively about being White when she is with other White children who do not tease her. Juan is happier being Dominican with other Dominican children, but speaks English with non-Dominican children. The playground, school hallways, and the lunchroom are battlegrounds when adults are not around.

Teachers report that they generally induce positive affects in children about their own race and ethnicity. However, some children prefer to study with teachers of their own race, because they might better relate. Jennifer, who is White, feels positive with teachers of all races. Although, she says that she might feel strange with a teacher she did not know well. Juan, the Dominican boy, is fine with everything. He believes that all teachers are trying to help him. Kim, a Cambodian girl, displays a neutral affect with all teachers, but prefers a Cambodian teacher who speaks Khmer.

Children also acknowledge positive and negative aspects of identities. Children take notice of their positive attributes (17.8%) such as Cambodians or Dominicans being good people. Children perceive bilingualism as an asset (13.4%). For example, a Dominican child knows his/her cousins in the Dominican Republic only understand Spanish, but his/her classmates or teacher only speak English. On the other hand, negative aspects of identities focus primarily on physical characteristics (21%) such as skin color. Children are very aware that people treat them differently because of their physical characteristics or cultural activities.

Children live simultaneously with positive and negative poles of their identity. Kim likes Cambodian food and the fact that her family is from Cambodia. However, she dislikes that there is war in Cambodia and that she has been treated badly by others. Juan likes his family and friends, speaks two languages, and loves Dominican food. He dislikes nothing and feels very good about himself. Jennifer enjoys playing games and likes the color white and wearing lipstick. As a minority in the school, she dislikes being called "Whitey".

In terms of engagement with school, we have found that children are concerned with doing well academically and being good overall. Immigrant, Asian American, and Hispanic American children are concerned about following the routine school-related tasks rather than the mastery of knowledge. Going to school everyday and doing one's homework rate high, but cheating is considered acceptable. In focus groups, these children said that in order to make it in this country, rules must be bent.

Our analysis also examined academic support. Parents are a large source of academic assistance for children from non-immigrant families (71%) and children from immigrant families (45%). In addition, siblings and older relatives provide academic assistance within immigrant families (24%) and non-immigrant families (9%). Language and formal education are key components of parental involvement. Non-English speaking parents and parents who have not received formal education may not know how to provide academic assistance and may feel linguistically alienated.

Children's experiences with discrimination vary. Juan says that he loves his skin color, but would change it because every time he turns on the TV everyone is White. Juan is glad that he is light-skinned because, "Black people are treated badly in this country." Kim says that she is teased for the way she talks and looks. In some cases, children anticipate discrimination. Kim worries that teachers and children hate Cambodians. She thinks that some people do not want to be friends with Cambodians. David worries that non-Indian children will tease him, and Jennifer is concerned that people will call her "Whitey."

We used the Perceived Racial Stress and Coping Apperception Test with our sample. We found age, race, and immigrant status differences for perception of conflict. Younger children generally do not know why target individuals were treated badly. African Americans tended to attribute negative treatment to racism or ethnic bias, while others seldom mentioned racism. Immigrants were more likely to suggest that victims "asked for" negative treatment.

Children have diverse coping strategies for hypothetical situations of ethnic and racial conflict. Younger children tended to use less effective strategies (i.e., begging) compared to older children who were reliably more effective (i.e., speaking to a teacher). Asian and Latino children suggested withdrawing from a situation of conflict, while White and African American children stood up for themselves in a conflict or found support from adults. Immigrant children suggested ineffective strategies compared to non-immigrants, such as walking away from a conflict.

To reiterate, the summary of our findings are as follows.

Age: Younger children are more likely than older children to: (a) choose unexpected identifiers, (b) select answers that relate to family and languages rather than to nativity or geographic factors, (c) demonstrate less knowledge of their own racial, ethnic, or immigrant backgrounds, (d) report much less bias or discrimination in projective tests, (e) report similar affective reactions in varying social contexts, and (f) give fewer, simplistic, and ineffective coping strategies.

Immigration Status: Children from immigrant families are more likely than their non-immigrant counterparts to: (a) list roles and nationalities as their best descriptors, (b) value routine tasks associated with school rather than the mastery of knowledge, (c) report their home environments to be conducive to studying, (d) blame victims for being treated badly in interracial/ethnic situations, and (e) give simplistic and ineffective coping strategies.

Race/Ethnicity: In an open-ended format, Latino children are more likely than others to deny negative stereotypes in defining themselves. Ethnicity is the most important domain to Latinos in selecting labels, while gender was the overwhelming choice for other children. Latino and Asian children are likely to value following school routines. Asian and Latino children report less effective conflict resolution strategies compared to their White and African American counterparts. African American children are more likely than others to perceive racial/ethnic conflict in ambiguous situations.

The salience and affective reactions associated with children's racial, ethnic, national, and other identities differ in various relational contexts. Parental immigration status often exudes as much or more influence over a child's various identities as the child's own immigration status. Siblings and older relatives play major roles in immigrant children's academic support systems. Although immigrant children express greater investment in following school-related routines, they appear to be less concerned about mastery of knowledge.

Many questions still have yet to be answered: What factors predict whether or not a child endorses society's racial and ethnic hierarchies? How can the consequences of anticipated

discrimination and racism be measured? Given such variability, are forced-choice identity measures viable? What is the role of specific knowledge of out-group stereotypes? Can qualitative measures tell us what quantitative analyses cannot? It is my hope that as we understand how children make sense of the world, their relationships with teachers, and their relationships with other people in power positions, that they develop a view of a benevolent and supportive world rather than a negative one.

Howard Markel: The other day I was at the National Archives. Near the researchers entrance, carved in marble is the axiom, "What is past is prologue." It is important to say that what we have done in the past is culturally embedded.

As President John Kennedy once said, we are a nation of immigrants. However, each observer tells the story in markedly different ways, reflecting individual views, sources, intellectual contexts, and social beliefs. Many individuals endorse immigration as a positive contribution to the nation while just as many others have decried immigration as an abomination that will inexorably lead to our decline and ruin as a country. Observers of contemporary debates on American immigration policies should take heart in the fact that this is hardly a new debate.

American historians have minimally studied the problems that develop when immigrant children and native-born children of immigrants are examined by physicians of completely different cultures, beliefs, and languages. During the first great wave of immigration, 1890 to 1925, there were three arenas in which children of immigrants came in contact with health problems or health professionals: (a) the American city, (b) the medical inspection of public schools and students, and (c) the urban pediatric dispensaries and milk stations that served impoverished children.

These three arenas will be the focus of my talk this morning. In addition, a brief glimpse at children of a century ago will illustrate that many social and cultural differences contributed both to negative and positive health outcomes. Such backward glances are not only of interest to historians of a long-ago era, but can provide a social context for some of the emerging problems seen today as children's health care professionals grapple with providing health care for increasing numbers of patients from different lands.

The 1890s were hardly a carefree period in American history. Economic depressions, massive immigration, and the rise of industry and urbanism all contributed to the deleterious health conditions of American urban centers. Wealth protected many against the harsher environmental conditions, but for those living in the poorer sections of these cities it was a difficult and dangerous existence.

Dirt, filth, noise, overcrowding, and bad odors pervaded almost every aspect of daily life. Foodstuffs ranging from wilted vegetables to rotting fish were sold on open pushcarts in the streets. Transportation was horse-drawn and massive amounts of dung marked their trails. Sewage systems, particularly in the poorer districts of the American city, were unreliable and often backed up into already soiled and filthy streets. Toilets in tenements were often in the form of privies and outdoor outhouses that were inconsistently cleaned by night soil removers. Baths were occasional events in the lives of many poor urban immigrants.

Epidemics such as diphtheria, small pox, and whooping cough were almost annual events during this period. Each summer brought waves of cholera infantum, or summer diarrhea, when thousands of American babies died of dehydration. This was an era when 200 out of every 1,000 babies born died before their first birthday and one out of five children died before their fifth birthday. Death was a very common visitor to American families' homes, especially those of immigrants. Furthermore, immigrant children born into families with the fewest social support mechanisms were especially vulnerable to abandonment.

It was also an era of child labor reform, with wide-sweeping social and legislative responses to the hundreds of thousands of impoverished immigrant children being enlisted into the workforce long before their minds or bodies were up to such challenges. Prior to this legislation,

at the turn of the 20th century, children as young as age 6 worked in dirty, overcrowded workshops operating heavy, dangerous machinery. Other children survived in the streets hawking newspapers, delivering messages, committing petty crimes, and procuring narcotics and prostitutes.

Immigrants were Americanized by health and hygiene measures. Following the exciting discoveries of the germ theory of infectious diseases, public health workers espoused a new philosophy that would make great inroads toward improving the nation's public health and the assimilation of the foreign-born. They began teaching immigrants and their children and native-born Americans about proper hygiene and personal cleanliness.

Immigrant social groups, health departments, civic improvement organizations, and many professionals worked to develop culturally sophisticated public health campaigns that explained personal hygiene in a variety of handbooks, pamphlets, newspapers, and magazine articles. The overwhelming majority of these materials reveal a measured understanding of the language and cultural differences that existed among the immigrant communities. This advice did not always originate from native-born Americans or health care professionals. Much of it came from immigrants themselves. Ideas about race, nationality, intelligence, and potential for assimilation were markedly different from our own.

Coinciding with the rise of the public health movement at the turn of the century was the rise of the public health school education system. At that time, local school districts rarely grew as quickly as the student population. Urban schools were crowded, poorly lit, and under-ventilated with inadequate plumbing and sewage. It was a very difficult place to go to school, particularly in the poorest districts in the United States. During the first third of the 20th century, children's health professionals became very interested in these issues and developed systems of school inspection to insure that no student had a contagious disease.

In this era without antibiotics, the only effective means of stemming the tide of an epidemic was to quarantine children with serious contagious diseases. By the 1920s, such programs expanded to include school nurses and dentists as well as engineers who examined school structure and layout. It became a sophisticated way of ensuring that school children were in good health.

Health leagues, hygiene classes, and mothers clubs were perhaps the most exciting way to teach immigrant children and their parents by extension about the importance of good health and hygiene. Many tensions arose as members of a dominant culture provided health care and education to immigrants inside and outside the public school setting. Several historians have described the "ambivalent progressive stance" taken by many urban professionals assigned to work among and care for immigrant communities. Many shared negative, American-born Protestant, middle-class views about immigrants flooding into American cities prior to World War I. However, their zeal for reform compelled them to work toward improved immigrant health.

A great site of activism during the progressive era was the dispensary system. These free-standing clinics existed to provide care for the urban poor and to train future doctors. Some of the earliest doctors in America began working at an urban dispensary.

Most immigrants, with few other health care options, utilized the dispensaries despite the cold and callous medical personnel. Nevertheless, New York City's dispensaries, for example, increased in size. They served about 135,000 patients in 1860. By 1900, in the middle of this first wave of immigration, over a million people in New York City were getting their primary health care from dispensaries.

Dispensaries did a lot more than just serve as a site for immediate or acute health care. Doctors and nurses also worked in the communities. The Milk Depot, a program started by a pediatrician and a member of the Macy's Department Store family, distributed clean, free milk to children from low-income families. In an era before refrigeration, milk was not always well handled as it was taken from farms to the city by horse-driven cart. It was often sold in pails dipped out on a pushcart and was kept out on a fire escape. Needless to say, sometimes milk

became infected with gastrointestinal viruses and waves of diarrhea spread throughout urban cities, especially among impoverished immigrant children. Diarrhea resulted in dehydration and often mortality among infants and small children.

We should not conclude that dispensaries were the ideal means of providing health care for immigrant children. Differences in class, culture, and ethnicity between the providers and patients created problems. The dispensaries, although imperfect, were: (a) the birthplace of the well baby examination, (b) the training ground for two generations of American pediatricians and children's health care professionals, (c) an integral part of the movement to provide clean milk for poor infants, and (d) the primary site of medical care for the majority of first generation immigrants in American cities during the progressive era.

Americans are particularly prone to relegating valuable lessons from the past to the overflowing dustbin of history. It is an unfortunate national trait, as we begin to consider the needs of immigrant children living in the United States today. Indeed, there is much to be gleaned from the social activism and the sense of community responsibility that spawned the health efforts at the turn of the 20th century. While cultural disparities existed between foreign-born patients and American health care professionals, these health care efforts were remarkably successful. Infant mortality rates dramatically decreased during the course of the 20th century.

The catechism of scientific motherhood was preached to native-born American mothers as well as their immigrant counterparts across a huge spectrum of socioeconomic classes. The student health conditions in American schools were significantly improved by standardized school inspections, health care services, and mass vaccination and nutrition programs. In addition, a legion of health care professionals ranging from pediatricians and nurses to social workers and bacteriologists obtained training within these settings.

In our current of anti-immigrant sentiment we find a return to social and economic scapegoating and a distressing potential for punitive laws directed at immigrants with regard to access to health care. There also exists a morass of confusion regarding the distinction between legal and illegal immigrants.

In a social milieu where federal, state, and municipal welfare support systems are being markedly altered or scrapped altogether, it behooves those of us concerned with the needs of this diverse patient population to consider the vital partnership that once existed between philanthropic social agencies, public health and medical professionals, school teachers, social workers, the immigrant communities themselves, and the government. All of these historical actors and social institutions played integral roles in improving the physical, mental, and social welfare of the newcomer.

At the same time let us not nostalgicize these efforts as a utopian vision of how things ought to be. Volunteer efforts then as today often combined diverse groups with markedly differing goals and agendas. Such efforts are as fragile as a powerful engine whose parts are held together with chewing gum. There are engineers who can pull off such a feat, but only with backbreaking work and constant attention.

Many of today's immigrant health care issues, including language, education, and culture barriers are similar to those of a century ago. Due to abrupt and chaotic human migration patterns, a number of new paradigms have emerged. For example, the new immigrant groups of the eighties and nineties have had difficulty creating social support networks as compared to their predecessors of a century ago. Furthermore, many immigrants from Africa, Eastern Europe, the Middle East, and other politically unstable areas are currently fleeing from their native lands to seek political asylum. A large percentage of these immigrants have experienced some form of physical torture or abuse.

Another challenging group consists of illegal immigrants who smuggle themselves across United States borders and major airports. Undocumented by definition, these immigrants have little if any access to health care. The potential for significant problems within this underserved population, including epidemic disease, is alarming. One might ask, do punitive health care

laws that punish immigrants who seek health care protect or not protect the public health?

As pediatricians and children's health professionals, we have a major stake in the success of meeting these challenges with creative and culturally sensitive solutions. These include the refinement and development of community and school based clinics in immigrant neighborhoods, linkage of such efforts with educational training programs for today's health care professionals in training, and active research that investigates the social, cultural, and health needs of these diverse communities.

Surmounting obstacles seems to accompany almost every valuable human endeavor. Often these obstacles seem so great in magnitude that they inspire frustration, avoidance and alas, indifference. Yet, history teaches us time and again to seek better solutions than the tried and true response of social paralysis. The history of American child care over the past century suggests that we are all soundly up to this challenge.

Heike Thiel De Bocanegra: I want to expound on what one can take away from this session to consider in program design, implementation, and evaluation and study design. My comments are divided into five categories: (a) use of census data, definition of study sample, and users of our services, (b) intragroup diversity and organization of immigrant communities, (c) measuring multiculturalism in research, (d) measuring back-and-forth migration, and (e) documented/undocumented immigrants and access to health care.

Census data are a rich source to determine sociodemographic characteristics and longitudinal trends. However, I would like to caution you that census data are very limited. Census data do not include health statistics. Furthermore, they undercount minority and low-income parents, as well as immigrant parents. When one looks at census data one has to be aware that a large number of the population is missing. Thus, the situation is actually a bit worse than the data reflects.

Another problem with census data and data from the Centers for Disease Control and Prevention (CDC) is that they use a mixture of racial, ethnic, and geographic identifiers. For example, Asian Pacific Islander is used as an identifier, yet it is a geographic region, not a race. This information is very meaningless for program planners.

Donald Hernandez pointed out the risk factors for children from 12 specific countries. Often one does not know if those children are in one's program. One is accustomed to categorizing people into Hispanic, African American, and White. One really does not know how the population changes over time.

Country of birth data are very important in terms of health statistics. If one looks at maternal child risk profiles, for example, children of foreign-born Latina mothers have lower infant mortality rates than children of U.S.-born Latina mothers. Furthermore, controlling for socioeconomic status, African American children of foreign-born mothers have lower infant mortality rates than children of U.S.-born mothers.

If one does not describe one's client population by place of birth, then one often does not become aware of demographic changes. For example, data may represent 60% Latinos, yet over time that data might shift from referring to Puerto Ricans to Mexicans or Colombians. With different population groups come very different health risk profiles and health beliefs. There is a marked difference if one serves a Chinese person or someone from Bangladesh. Yet, all are Asian.

There is great diversity within each group. When one looks at census data one sometimes forgets that characteristics of people coming from the same country change over time. I call this intragroup diversity. It is helpful to examine waves of immigration when analyzing poverty for example. An example is the Senegalese immigrants who come to New York City. The first wave of immigrants tended to be better educated, from urban areas, and able to speak a dominant language. For many years, hospitals in New York City provided a French interpreter to the first wave of Senegalese immigrants. The second wave consists of less-educated people from rural

areas who only speak indigenous languages. Hospitals are now scrambling to find appropriate interpreters. These sorts of waves occur in nearly every group. It is helpful to determine where each immigrant fits into the immigration wave.

The first wave of Chinese immigrants to New York City came from the Provinces of Canton, Hong Kong, and Taiwan. Yet, now more are rural peasants from the Province of Fukien. There is not automatic solidarity among immigrant groups. For example, the first wave of Chinese immigrants is not that excited that the second and third waves are occurring. First wave immigrants might fear that latter waves might destroy their image. On the other hand, recent arrivals from Mainland China can count on community-based organizations and community structures that are already in place for the Chinese community. Thus, they are at an advantage compared to other immigrant groups like those from Bangladesh or from Pakistan who are just beginning to build up their social support networks.

There are certainly different degrees of cohesiveness, structure, and leadership in different immigrant groups. Such varying degrees of organization influence the level of information and accuracy about available educational and health services, and implications of welfare and immigration reform.

My other comment is concerning the measurement of multiculturalism. When one tries to study children of foreign-born parents one has to keep in mind changes that have occurred since the beginning of the century. One hundred years ago, immigrants came to live in the United States to build a future here for their children and stay forever. Today, immigration is not a one-way street.

At present, there is a greater overlap among cultures than at the beginning of this century. Immigrants already have a certain image of the United States through Hollywood movies and through the news. Once here, immigrants keep in close touch with their home country and aspire to return home one day. People receive medical advice and medication from their home countries rather than here in the United States. The most recent wave of Polish immigrants in New York City return once a year to Poland to receive annual physical checkups because the U.S. system is too confusing to figure out.

The idea of returning home certainly has numerous implications for U.S. educators, such as whether parents feel an urgency to learn English, seek educational options for themselves and their children, establish a home, and become a U.S. citizen. Furthermore, it impacts whether one becomes active in community improvement, in the school, and keeps one's cultural background.

As Cynthia Garcia Coll said, multiculturalism means that one does not have to decide necessarily whether one belongs to one culture (i.e., Mexican) or is now an assimilated American. Multiculturalism really means that one is able to switch from one culture to the next and can decide what to keep or discard from each culture. In this sense, I found it interesting when Garcia Coll spoke of how the children define themselves in multiple ways. We always try to put people into boxes. A person is either Mexican, Mexican American, Chicano, or Latino, but cannot be all four.

Rather than think about the U.S. as a melting pot where one has to assimilate at all costs to a mainstream culture, one should think of the U.S. as a salad bowl. In a salad bowl, the tomato stays a tomato, and the cucumber stays a cucumber. Every ingredient keeps its own flavor, yet together make a nice mixed salad. That is how I envision the United States. Multiculturalism is not a threat, but is enriching.

Back and forth migration causes incomplete family units. Many times one parent lives in the US, but is waiting to sponsor his/her children. In addition, in order to save on child care expenses, preschool children might be sent to their native country to live with grandparents for several months or even years. There are long separations. Sometimes children have not seen their parents for years, which has implications. For example, due to such separations, parents might not know what childhood diseases their children have had. In addition, some children

may resent and not understand why their parents left them back home with grandparents or other family members. It would be interesting for future research projects to examine to what extent prolonged contact with the parents' native country influences a child's development and as well, the child's cultural identity.

It is important to address undocumented immigrants and their lack of access to health care. My first reaction is that children in New York City do have access to health care. However, the White House initiative provides health insurance for children, but only legal children. The implementation of the Child Health Plus (CHIP) program varies by state. Since 1990, the CHIP program in New York has provided child health insurance independent of legal status. In addition, through CHIP, perinatal care is offered to low-income women independent of their legal status.

A significant under-enrollment in Medicaid and Child Health Plus is observed in New York State. The Children's Defense Fund estimates that 700,000 children are eligible but not enrolled in the program. There are many concerns about why parents do not enroll their children. First, immigrant parents fear that one's legal status is not handled with confidentiality. They fear that the data will be reported to the Immigration and Naturalization Service (INS) and then lead to deportation. Second, parents are concerned that an application to Child Health Plus or Medicaid might affect their ability to become a resident or a citizen. A culturally competent system must be developed to encourage people to enroll. Sometimes one thinks that individuals simply did not want to enroll in child health insurance, when in fact it is the system that is not user-friendly nor responsive.

In conclusion, this session revealed many implications for outreach and meaningful research. First, researchers, practitioners, and policy makers should routinely identify new immigrant groups. Such information is crucial to program planning. Second, one should avoid labeling and acknowledge multiculturalism. Third, one should work with immigrant community organizations to better understand what is happening in the community. Finally, one should develop culturally competent programs that address the concerns of immigrant parents.

Plenary III

Child Care and Economic Changes for Low-Income Families

CHAIR: John Hagen
PRESENTERS: Sheldon Danziger, Deborah Vandell

- **America Unequal: Why the Working Poor Have Gained So Little**
  Sheldon Danziger
- **Child Care for Low-Income Families: Dreams and Real Life**
  Deborah Vandell

John Hagen: One of our presenters, Aletha Huston, could not be here today. Our first presenter is Sheldon Danziger who received his Ph.D. in Economics at MIT. For many years, he was Director of the Institute for Research on Poverty at the University of Wisconsin. I am very pleased to say that he has been my colleague at the University of Michigan for the past decade. He is a professor of Social Work and Public Policy and also directs a Center on Poverty Risk and Mental Health. Even though his background is primarily in economics, he has spent a good deal of time interacting with, doing research, and learning from people in some of the other behavioral sciences. He has said that these interdisciplinary exchanges have greatly influenced the course and direction of his work.

Our second presenter, Deborah Vandell, received her doctorate from Boston University. She is a Professor of Educational Psychology at the University of Wisconsin, and has been one of the primary investigators on the large-scale NICHD study on child care. She also has been involved in research on aftercare programs for school-age children.

Sheldon Danziger: If you have been reading the newspapers, particularly *The Wall Street Journal*, you know that these are the best of economic times. On average, that is right. However, one of the things we teach our students is that just looking at the mean and the median does not tell one about what the full distribution might look like. As someone interested in poverty and equality, I think it is particularly important to realize that in economic outcomes, knowing the mean or the median has been a lot less informative in the last two decades than it was in the great economic boon following World War II.

Previously, if the rich, the poor, and the middle class were moving ahead at roughly the same rate, then knowing the mean or the median gave one a pretty good notion of what was happening to those at the bottom of the income distribution. However, since the early 1970s, that has not been the case. In fact, I think that is why I am probably here in this session today. The change in economic outcomes has implications for how many families are going to be able to

take care of their children. This issue has particular implications now that in this time of welfare reform single mothers of children as young as 13 weeks old in Michigan are expected to be in the labor force. Some states require mothers with children of 12 weeks to be in the labor force.

As I said, these are the best economic times, but I would qualify that by saying it is undoubtedly true if one is college educated, has technical skills, and works for an employer with a pension plan and health coverage. Even if one does not get the kind of stock options that Wall Street investment bankers get, this person's employment prospects are excellent if he or she decides to switch jobs now. Such individuals also have probably had large increases in the asset value of their pensions. However, those who are high school dropouts or even those who have graduated from high school, have experienced, at best, stagnant and mostly declining real wages in the past quarter century. Again, it is ironic that finally in 1997 and 1998 wages on average are rising somewhat faster than inflation.

Today, despite a robust economic boom and very tight labor markets, by 1996 income growth had not trickled down at all to the poor. This is the latest year for which we have census data. Data for 1997 will be available in October.

The American labor market has undergone dramatic changes beginning in the early 1970s. We went from an era where a rising tide did lift all boats to one of uneven tides; one in which the prospects of those at the top and those at the bottom are totally, or virtually separated. A number of different factors have influenced this change.

Economic hardship remains widespread despite the economic boom, particularly for workers with only a high school degree or less, and especially for single mothers. Many families have only avoided poverty and economic hardship because of the increasing employment and earnings of married women.

In the 50 years since World War II, for the first 25 years men's wages were the engine of family economic growth. Looking at the difference between family income in the late 1940s and the early 1970s, the main factor accounting for economic growth was the rising real wages of men. Over the next 25 years the reverse is true. Men's real wages, on average, have actually gone down and most of the economic growth, and certainly the engine of family economic growth, has been the rising earnings and work hours of married women. Put together, this says that two-parent families have kept up because wives have worked longer hours and have earned more. Obviously, single parent families have not had that opportunity because there is only one wage earner.

There has been a tendency to see the struggles of middle-class families to meet mortgage payments and college tuition expenses as unrelated to the problems of low-skilled workers who have a hard time providing health insurance and day care for their children. Yet, I want to argue that the same economic changes that have affected the economy at large are affecting both the middle-class, less-skilled workers and the recipients of public assistance. I would argue that the problems of the poor, the less skilled, and recipients of public assistance are not the negative effects of well-intentioned government policies that have distorted the work ethic in family behavior. It is not the case that the poor are rejecting work opportunities; rather it is the case that employers are rejecting the poor who do not have the skills needed in today's economy.

There is consensus among economists that many factors are involved. A shrinking percentage of the work force belongs to unions. There is a shift in jobs away from manufacturing; globalization and technological change with the widespread introduction of computers have increased the demand for skilled personnel and reduced employment for less-skilled workers.

I also see a new trend based on my own recent experience. It strikes me that the ability to buy airplane tickets on the Internet is now going to reduce jobs for travel agents. I would spend so much time on hold trying to get my travel agent, I realized it was easier to buy tickets on the web. If travel agents are not used as frequently, this becomes a higher-skilled job, not a low-skilled job, being displaced by technology.

Of course, it is true that poverty is higher than it otherwise would be if poor people were to

marry more than they currently do, or would work more than they currently do. That is why, I think, it is easy for people to say, "Well, if single mothers would marry then they would have the same poverty rates as married couples." The problem then gets defined as their failure to marry, which has nothing to do with the economy.

I would argue that poverty stopped falling not because of the War on Poverty, the Great Society, the Civil Rights Movement, or the Women's Movement, which would be what the Heritage Foundation would say, but rather that poverty stopped falling because of the change in the economy. My key point is that the economic situation is difficult for male high school graduates who are in the labor market. If they are having a very difficult time earning enough to support a family, what can we expect mothers receiving public assistance to do? Half of these women are not high school graduates and have more child care responsibilities than men.

If one looks at what is happening in the labor market, the implications are clear. If we expect mothers with children of 3 months to work or to lose their public assistance there must be an enormous expansion of available child care programs, including Head Start. Full-day and full-year programs, at earlier ages, must be provided for their children.

In the good old days, when President Nixon proposed welfare reform, he was quite explicit about his expectation that mothers who were recipients would work. In retrospect, things look different, but President Nixon was the liberal who proposed a guaranteed annual income in his Family Assistance Plan. He was tough on work but added, "A welfare mother with preschool children should not face benefit reduction if she decides to stay at home. It is not our intent that mothers of preschool children must work."

At the same time that the last 25 years have been marked by increased economic difficulties, in the area of welfare, we have begun to expect mothers with young children to work earlier and earlier. In the good old days of President Nixon, only mothers whose children were in school were expected to work. By 1988 with the Family Support Act, mothers of children age 3 or older were expected to work. One could say, "If Head Start is available for children at age 3, it is reasonable to expect mothers to work." That was one option. At that time, a person could not lose his or her welfare benefits if the state could not find child care arrangements.

Today with welfare reform, it is obvious that states need not do anything other than offer a wage and a child care subsidy. The state says, "Your child is 13 weeks old, so it is time to go to work. We will provide $2 an hour and here is a list of places for you to find child care. If you are not working within 3 months, we will start thinking about sanctions." So, at the same time when the economy has become more difficult, our expectations of mothers who receive public assistance have increased.

Clearly it is the case that we live in an era of rising inequality. The bottom 20% of families are essentially 9% lower in real income. Even adjusting for inflation, the bottom 40% of families are either worse off or not better off than they were roughly 25 years ago. There have been small gains in the middle, and large gains only at the top.

The good news is that we are better off than we were in 1973. If one looks roughly at this earlier period, one sees an increase in real income from about $20,000 to about $40,000—quite dramatic increases—which were widely shared, followed by slow growth and rising inequality. That is why I say that in the years 1997 and 1998, if we see some real income growth and wages finally going up at the bottom, we need to look how low the base is from which we are starting. We also need to look at what one has to overcome to reach income equity in light of the past. For those who would like more data on the early period, I refer you to a book I wrote with Peter Gottschalk entitled *America Unequal*.

There is much criticism from conservatives regarding the war on poverty. They maintain that it was a failure, saying that poverty was doing just fine until the war on poverty came in and then everything fell apart. It turns out that in every recession since 1973, poverty increases. That is not a surprise—poverty rates go up in a recession and then when there is an economic boom, they come down. So, in 1996, I was predicting poverty rates would be much lower, but I was fooled. Even if

the rates are lower in 1997 as I predict, we are at the level where we were officially in the late 1960s. Now, things are not quite so bad because the poor today receive an earned income tax credit, Medicaid, and food stamps. The point is that this is the situation that the economy generates.

Jim Tobin wrote when he was working for the Council of Economic Advisors in the late 1960s that he thought poverty would be eliminated, using the current definition, by the Bicentennial. My mentor at Wisconsin, Robert Lantman, had said poverty would be eliminated by 1980. Why were they wrong? They thought that we were going to continue in an era when a rising tide lifts all boats. The key element is the declining real earnings of male high school graduates. These numbers are both easy to interpret and more relevant when one thinks about putting mothers receiving public assistance to work and expecting them to support their families.

In 1995, the median earnings of White males, $18,800, is less than the median earnings of African American high school graduates in 1969 by a small margin, and less than the median earnings for White males in 1969 by a large margin. I quote figures for high school graduates, even though about half of mothers receiving public assistance are not high school graduates. I think it is reasonable to assume lower earning expectations for young, single mothers forced to leave public assistance.

When one talks about a period of rising inequality and declining real wages, it is apparent for Whites and African Americans. Numbers are similar for Latinos and other groups. During the great post-World War II economic boom, in the earning range from $15,000 to $27,000, there was an even more rapid percentage increase for African Americans during the same period, with rapid economic growth and the civil rights movement in the late 1960s. The average income almost doubled in this period.

One additional comment on economic data is that women on average have done better than men over this period and their earnings are higher than income for African American men. However, the lines slope upward, which is another indicator of rising inequality.

We move here from looking at only high school graduates to looking at everybody—all age groups—roughly, full-time workers between the ages of 22 and 62 who worked at least 39 weeks during the year. Again, this is a broader spectrum. What one sees is that basically men, roughly in the 75th to 80th percentile group of the earnings distribution, had losses over this 20-year period.

While there has been real wage growth for women, at the same time there has been rising inequality for both men and women. For public assistance recipients, who are likely to be in the lower part of the earnings distribution, there has not been much in the way of real wage growth. Those who were involved in welfare reform knew about this phenomenon. Nonetheless, I think there was the overriding expectation that the problem of welfare was that it encouraged people to stay on welfare.

Essentially we have gone from a system one could characterize as allowing too many false positives to a system that has too many false negatives. That is, there is a widespread perception that too many people stayed on welfare for too long, that we wrote checks for too many people, and that there were some people who should not have been getting checks. Now we have gone to a system that has too many false negatives because it has not fully accepted what has gone on in the labor market—the increasing demand of employers for workers with more and more skills.

Over the last 10 years, employers have been increasing their demands for high school degrees, previous experience, and specific job skills. If someone has been receiving public assistance and is a high school dropout they do not have previous experience or a degree. We asked a random sample of public assistance recipients in Michigan whether or not they had developed desired skills on a previous job. The good news is many public assistance recipients have acquired some of the skills. However, it turns out that a significant number of them have not acquired the skills. In particular, it is not surprising that some of the skills that are virtually required of even the most entry-level office job these days, such as working with a computer, writing letters or memos, are skills with which people have the least experience.

The good news is that a very small percentage of the sample knew none of the tasks sought by employers. Only 24% were working at least 20 hours a week, which is the requirement in Michigan. Forty-three percent of the sample who knew three to four tasks were working. If they knew four or more, 62% were working. In Michigan, one can continue to receive public assistance if one works 20 hours a week. Twenty-one percent of the sample had previously done zero to three of the desired job tasks. Thirty-four percent of the sample who knew zero to three of the tasks were working. Sixty-three percent who knew four or more were working.

In the Michigan sample, 30% of the recipients were high school dropouts. Twenty-six percent had the diagnosis of major depression, using the national co-morbidity survey instruments. Thirteen percent reported poor health, however 29% of this group are working 20 hours a week or more.

If one then does an Arnie Sameroff-type count of the barriers to employment, the good news is that most public assistance recipients in our sample have only zero, one, or two barriers. That is almost 60% of the population. Roughly two-thirds to three-quarters of them are working. However, when someone has in the range of five, six, and seven barriers, it becomes very difficult. If one counts up to five barriers, a mother receiving public assistance would have to be a high school dropout, have no car and license, have no previous job skills, may be at risk for depression, and have a child with asthma. How likely is it that she is going to be able to work?

I want to emphasize that when considering welfare reform keep in mind that the economy has turned against low-wage workers in general. Even male high school graduates who do not have responsibilities for children to the extent that women do are having a difficult time in the labor market. Realistically, many of the women who receive public assistance have significant numbers of barriers, and we have not even dealt with child care issues. So, if these women are going to be required to work, we will need some kind of public jobs program of last resort, because it is very unlikely that the private sector is going to be involved.

Even with the successes, the women working 20 hours a week or more are typically taking home about $100 a week. The earned income tax credit might offset some work expenses. In Michigan they still receive welfare supplements and subsidized child care. However, with time limits, states are pulling those away, and the prospects even for women with few barriers is not good. As I said, even though my expectations for the poverty rate were overly optimistic, I am not overly optimistic about the long-run ability of single mothers to juggle the demands of welfare reform. Given the continuing economic difficulties, at a minimum, greatly expanded programs like Head Start and others are clearly in order for recipients who have to work.

Deborah Vandell: Finding and keeping good quality child care is not easy for families with substantial financial resources. For low-income families the challenge is even greater. Enormous efforts by parents, family, and friends are often needed to patch together even fragile, temporary child care. Multiple factors contribute to this challenge. Child care costs absorb substantial portions of budgets, 25–33% for low-income families, compared to 6% for families at the median income level in the United States.

For low-income parents, work schedules are often more variable and include evenings and weekends, limiting the range of available child care options. Problems with transportation are common, making it difficult to get from home to child care, to work, and back again. Finally, high-quality child care is in short supply, especially for children under age 3. In facing these challenges, families have needed to adopt multiple strategies to meet their child care needs. In my presentation today, I will describe some of the approaches to child care that are being utilized by low-income families, including care in nonregulated child care homes, care by father and by grandparents, and care in centers.

We will consider the number of families who are using these different arrangements, the cost of care, and the typical quality. Then we will examine ways that this care affects mothers, their workforce participation, and their psychological well-being. Finally, we will conclude by

considering the effects of child care quality, type, and hours on children's development.

The passage of welfare reform legislation, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, makes this topic particularly timely. As more mothers move into the workforce, questions about the availability, cost, and quality of child care for low-income families must move to center stage. In some ways, the interest in and support for child care are at an all-time high.

In 1997, a White House conference was held to highlight recent research findings and exemplary efforts to provide high-quality child care services. In 1997, the total direct subsidy for child care, including state contributions, was $4.5 billion, with an additional $4.4 billion allocated for Head Start.

In 1998, President Clinton proposed a fiscal year 1999 budget that allocated almost $22 billion over 5 years for child care. Questions can be raised, however, about whether the requested funds will be sufficient to meet the child care needs of many families, most notably the working poor, those with infants, and those who work nonstandard hours. In my view, justifiable concerns also remain about the quality of available child care, especially for the poor and the near-poor. These concerns are heightened by research findings that show the detrimental effects of poor-quality child care on children's development.

Let me begin by describing one family's real-life struggle to work and to care for their young children. Marlene Garrett and her husband are both employed. Each morning at about 5 a.m., Mrs. Garrett takes her three children, ages 11 months, 3 years, and 4 years, to an unregulated child care home. It is very early in the morning because Mrs. Garrett has to be at the bagel shop where she is employed by 6 a.m. Although the child care setting is clean, there are few toys and no planned activities. The children spend most of their 10-hour day watching television. Vivian, the child care provider, works evenings at a local laundry and is undoubtedly tired each day. Mrs. Garrett has concerns about the quality of care that her children are receiving. Mrs. Garrett would like them to attend a local child care center. At $180 per week, however, center-based care is out of her reach financially. She says, "I want them in a learning environment, but this is the best I can do right now." It is an emergency situation.

The Garretts are not alone. According to one national survey, 35% of low-income children in households with children under the age of 13 are two-parent households. Nine percent of all low-income households that are living in poverty are dual-earner households, as are the Garretts. Mrs. Garrett's work schedule is also not uncommon. Almost half of all working poor mothers are working on rotating or changing schedules, compared to one quarter of the middle-class mothers. One-third of the working poor work on weekends. These schedules make it difficult for families to use child care arrangements that are in regulated child care homes or in centers because those settings often do not offer care late in the evenings or on the weekends.

In any given month, mothers are more likely to exit jobs when they have more children. Mothers with more children are less likely to be employed. It is also not surprising that families are more likely to use child care and to use it for more hours when they have fewer children. The Garretts' situation also demonstrates the gap between the households who qualify for child care assistance and those who are actually receiving subsidies.

With three children and a combined take-home income of $450 a week, the Garretts have qualified for a child care subsidy in the state of Florida, but they are on a long waiting list. During the fall of 1997 when they were interviewed, 25,000 children were on the waiting list for assistance in Florida and an additional 39,000 children were eligible for assistance. Because the bulk of the funds have been budgeted for public assistance recipients moving to jobs and not to the working poor, it is unlikely that the Garretts are going to be receiving a subsidy any time soon. Waiting lists in other states are equally formidable. Even prior to the passage of welfare reform in 1996, there were 40,000 children on the waiting list in Texas and 7,000 children on the waiting list in Minnesota.

As they wait for their subsidy, the Garretts have turned to Vivian, who provides nonregulated child care from her apartment. This is a common solution. According to the national child care survey, about 20% of the children under age 4 whose mothers are employed are in child care homes, with an estimated three-quarters of these children being placed in homes that are neither registered nor regulated.

Observations indicate pervasive differences between nonregulated and regulated child care homes. As a group, providers in regulated child care homes are more likely to have formal training, participate in the food program, and to be a member of a child care association. Nonregulated providers are less likely to see child care as a chosen profession and more likely to see it as a temporary job. They are less likely to plan activities and more likely to do housework when their charges are present.

In general, caregivers in nonregulated homes appear less sensitive to their children's needs and the caregivers themselves report that they are more restrictive with their charges. When assessed using the Family Day Care Rating Scale, an instrument that rates child care homes in terms of health, safety, learning opportunities, and caregiver warmth, observers in one study reported that 50% of the nonregulated homes were inadequate versus 13% of regulated child care homes.

Three percent of the nonregulated homes were judged to be of good quality, as opposed to 12% of the regulated child care homes. If nonregulated homes are typically of poorer quality than regulated ones, why do parents use these nonregulated settings? Two factors undoubtedly contribute to the use of nonregulated homes by low-income families: availability and cost. Nonregulated homes are more likely than regulated ones to offer care during off-hours and their cost is substantially less. For low-income mothers who are working nonstandard hours for low wages, nonregulated child care homes are one of the few options. Although Marlene Garrett and her husband were similar to other low-income families in many respects, they are unusual in that unlike many dual-earner households they have not turned to shift work as a way of trying to finesse their child care needs. In these families, mothers and fathers work different schedules and parents then share caregiving. Most often, fathers are employed during a standard workweek and mothers work evenings, nights, and weekends.

Father care is particularly common with infants, which is the most expensive and difficult type of care for parents to find. Fully 23% of the infants of employed mothers are cared for by their fathers, making father care the single most common care arrangement for infants when mothers are employed. In low-income households with fathers and children under the age of 5, fathers are also the primary care arrangement, with 12% of working poor using father care.

While these shared child care responsibilities are less costly for families financially, there are other types of costs. Perhaps because they have less time together, these mothers and fathers tend to be less satisfied with their marriages than other families not relying on shift work. A report from the NICHD study of early child care gives us an indication of the quality of care that fathers are providing.

Fathers who served as the primary care arrangement were observed with their children at 6 and 15 months during half-day visits conducted at both of these ages. Three indicators of caregiving quality were assessed: (a) frequency counts of positive caregiving behaviors, (b) ratings of fathers' sensitivity and warmth, and (c) ratings of cognitive stimulation. The child care HOME, an adaptation of Bradley and Caldwell's HOME Scale, was used to assess the organization of the environment, provision of appropriate play materials, caregiver emotional and verbal responsivity to the child, and the variety of stimulation. Fathers in low-income families were observed to provide less quality care on the child care HOME inventory than father caregivers in more affluent households.

Father caregivers in the most affluent households were the ones who were most sensitive, warm, and stimulating in comparison to lower-income fathers who were caregivers. Thus, the observations of both father care and child care homes suggest that low-income children are less

likely than children from more affluent families to receive care that is cognitively stimulating or emotionally supportive.

Christine Berdemo is another employed mother who is trying to meet the child care challenge. The divorced mother of two children, ages 2 and 4, she works as a waitress. Her ex-husband is not available to help with child care. Like the Garretts, she would like for her children to attend a child care center, but she cannot afford the cost. Also like the Garretts, she is on the waiting list in Florida for a child care subsidy.

In the meantime, Mrs. Berdemo's father and her former mother-in-law are alternating babysitting duty. Her mother-in-law has agreed to help for just a while longer and Mrs. Berdemo does not know what she is going to do when her mother-in-law stops helping. Mrs. Berdemo's circumstances are similar to those of many other families. Single mothers head 53% of low-income households with young children. Of these 43% are employed. As a group, employed single mothers worked more hours and longer hours than other women and their needs for child care are substantial. Many of these employed single mothers, like Christine Berdemo, have turned to grandparents as their primary source of child care. In fact, grandparent care is the single most common type of care used by employed single mothers, with 35% of these households relying on grandparent care as their primary arrangement.

Several factors contribute to this use of grandparent care. Grandparents are sometimes preferred because mothers believe that kin are more trustworthy and more likely to respect family beliefs and values than nonfamily. Mothers also express stronger preferences for grandparent and relative care for their infants than for their school-age or preschool-age children. Cost is another factor, with care often provided at below the cost of other care arrangements in that community and sometimes is even free of charge. Care by grandparents functions as a private child care subsidy. Grandparents are also more likely to provide care during nonstandard hours and are more likely to work longer shifts.

Two recent studies indicate that grandparent care, like the care in child care homes and father care, is highly variable in quality, and, in some instances, the care is problematic. Using the same observation instruments that were used to assess father care and child care homes, the NICHD study reported that grandparents in poor and near-poor families provided less positive caregiving than grandparents in more affluent households.

One study also found relative care, which included grandparent care, to be of poor quality when families had fewer financial resources. Seventy-three percent of the children from very low-income families were in relative care that was judged to be inadequate versus 43% of the children from low-income families in relative care and 13% of the children from moderate-income households in relative care.

In other analyses, this study contrasted care provided by relatives to that of regulated child care home providers. Low-income children who were cared for by relatives received care that was harsher and less sensitive than low-income children who were cared for in regulated child care homes. Relatives were also less actively involved in caregiving than caregivers in regulated settings. Finally, caregiving quality by relatives was found to be poor when the care was offered as a favor to the mother and the relatives provided the care grudgingly, which makes me worry about the care that Christine Berdemo's children are getting from her mother-in-law.

Christine Berdemo's use of two different individuals for child care is another illustration of a child care reality. A national child care survey has reported that almost one quarter of low-income households are using more than one arrangement. In the NICHD study, which interviewed mothers every 3 months about their child care, multiple arrangements appeared to be even more common. For example, 45% of the infants whose mothers worked variable schedules were in three or more arrangements during the first year alone.

Thirty-six percent of the infants whose mothers were employed during the day, which is the most stable of the work schedules, experienced three or more arrangements during the first year. The logistics of choreographing multiple arrangements is emotionally stressful for

mothers, as both Christine Berdemo and I can attest.

Observations also indicate that young children are stressed by too many arrangements and by arrangements that are in flux. There is, however, one benefit to these multiple arrangements. They act as a potential backup when one arrangement falls through. Such safety nets do help mothers to remain employed. Mothers who have multiple arrangements are less likely to leave their jobs than those with a single arrangement are. However, there is a cost. We need to be thinking about ways of providing more stable child care arrangements.

Let us turn to another child care situation, that of Kelly McKnight, who is an employed single mother and who might be viewed as a child care winner. After 2 years on the waiting list, she began receiving a subsidy for her two daughters, ages 3 and 4, to attend a licensed child care center.

With its established hours, programs, and materials, child care centers are much desired by many low-income families. It is the second most common arrangement used by employed single mothers. Twenty-three percent of these mothers use centers as either a primary or secondary care arrangement. The use of centers, which includes Head Start, prekindergarten programs, and child care centers, is concentrated in older preschool children. Fifty-eight percent of 4-year-olds and 83% of 5-year-olds attend centers. Center enrollment for the poor and the near-poor is closely tied to child care subsidies. In the NICHD study, for example, 64% of the low-income children who attended centers did so with government assistance. The working poor and the working class who lack access to direct subsidies are less likely to use center care than either the poor or the more affluent.

We have already considered the quality of care in child care homes and in relative care. In each of these settings, there appears to be a linear relationship between family income and the quality of caregiving that was reported. Children whose families had higher incomes were observed to receive child care that was of higher quality, more sensitive, warm, and cognitively stimulating than did children whose families had less income.

The quality of center-based care, unlike these other types of care, appears to be bimodally distributed. In general, children from very affluent families and children from very low-income families are more likely to receive better-quality child care than children of the near-poor and working class. This pattern appears to be the result of child care subsidies and assistance. Children from the most impoverished families who received government subsidies to offset the cost of center care and qualify for publicly subsidized programs are receiving better quality care. Care in some cases is more comparable to that of the middle-class. The near-poor and working class families, however, are less likely to receive any assistance and they lack the funds necessary to purchase good quality child care.

The child care that is available to them is much more likely to be of poor quality. Collectively Mrs. Garrett, Ms. Berdemo, and Miss McKnight illustrate also how fragile the work-family-welfare balance is for many. In the face of high child care costs, variable work schedules, long work hours, and concerns about the quality of care that their children are receiving, many poor and near-poor women must stop working if assistance is not forthcoming.

In one study, 25% of those on the waiting list for child care subsidies ended up on welfare. In the absence of government assistance, many mothers also continue working only with substantial assistance from family and friends. For example, the only way that Kelly McKnight could afford even her subsidized child care center is for her to live with her father, the girls' grandfather. This arrangement, like many others, however, is a temporary one, because her father's neighborhood is an adult-only community. Thus, her work and child care schedule remains precarious, even with a child care subsidy.

The working poor represent only one segment of the contemporary child care scene. In other low-income households, those in the deepest poverty, mothers are not employed. In 1990, single mothers who were not employed headed 35% of the low-income households with children under age 5. The single most common arrangements in these families, used by 48% of

the households, was for the children to be cared for by their mothers. Maternal care is often idealized as the best possible care for young children. The reality, however, is that exclusive maternal care often occurs in the context of deep poverty and minimal marketable skills. In the NICHD study, for example, infants and toddlers who were in exclusive maternal care as a group had mothers with less education than did children who were in nonmaternal care. Also, those households were the ones most likely to be continuously poor and continuously on public assistance.

Nonemployed, single, low-income mothers do use child care on a regular basis. In 24% of the households, grandparents or other relatives provide that care. In other households, children attend centers, including Head Start. Traditionally, children who participated in Head Start had mothers who were not employed, because in its original part-day, part-year format, it was difficult for the working poor to use Head Start. However, as a result of changes in welfare policy that link assistance to employment, supplemental funds have been added to the Head Start allocation to support full-day services, now with 50% of the Head Start programs offering full-day services, either in collaboration with other centers or with Head Start programs themselves.

I would like to turn to the impact of these child care arrangements on children's developmental outcomes, summarized in recent work released by the NICHD study of early child care. Prior child care research had looked at exemplary intervention programs and at community-based centers. In much of that work, there was a common theme of better quality centers being associated with better child functioning. These results were important and they have guided our research in the area of child care and children's development. This work, however, was also limited in that it was based on center-based care and typically used concurrent analyses of quality of centers and child functioning at a single point in time. As today's presentation has made clear, however, children are in many different types of child care. Because children are also cared for by fathers, grandparents, and in child care homes, it is important to consider child care effects across all of these different child care settings. It is also important for us to look at the cumulative effects of child care over time. This broader examination has been one of the goals of the NICHD study, the first large-scale, multisite study to consider children's developmental outcomes in relation to different types of care, quality of care, stability of care, and hours of care.

A total of 1,364 children were recruited shortly after birth. Included were children who were cared for by their mothers, as well as those in centers, child care homes, and those cared for by fathers, grandparents, nannies, and sitters. The sample is a heterogeneous one in terms of income and race. Multiple developmental outcomes, including cognitive and language development, preacademic skills, social competence, behavior problems, and attachment relationships have been assessed at multiple developmental periods, using multiple measures and multiple settings. Results from phase one of that project, taking children up to age 3, are now available. In general, the study illustrates the importance of the family, children's own characteristics, and child care characteristics for children's developmental outcomes.

Let me highlight just a few of those findings. The importance of both familial and child care factors have been indicated for children's intellectual performance measured at 15, 24, and 36 months. Children whose mothers had better vocabularies scored higher on cognitive assessments at those three ages. Children whose homes offered more stimulation and emotional support performed better in terms of intellectual performance than those in poor home environments. Children whose mothers were more cognitively stimulating performed better on tests of their intellectual performance. In addition, child care was an independent contributor to children's outcomes. Bailey and Bracken scores were higher when quality of care, as measured by caregivers' behaviors with the children, was higher. Children's cognitive scores were higher when caregivers talked more to children.

In addition, type of care was related to cognitive performance. Children with more experience in center-based care and less experience in child care home settings performed better on cognitive assessments. A final child care parameter, hours, was associated with cognitive performance

in conjunction with family income. Hours of care was negatively related to cognitive performance for children in the middle-income group, but positively related to children from low-income families and high-income families. This is again tied to the issue we talked about before: the differential, bimodal distribution of quality for those settings.

Children's language production was considered. At 15, 24, and 36 months, children said a greater number of different words and used more complex sentences when their home environments were more cognitively stimulating and emotionally supportive. At 36 months, their language production was more advanced when mothers had richer vocabularies and mothers were cognitively stimulating in play. Their language production was also related to their child care. Children produced more words and used more complex sentences when caregivers talked to them more and when the overall quality of care was higher. Children who had more experience in center-based care received higher scores for language production than children with less center experience, when overall quality was controlled.

Children's language comprehension was considered. At both 24 and 36 months, girls demonstrated better language comprehension than boys. Children had better language comprehension when their mothers had better vocabularies. There was better language comprehension in families with higher incomes than in families with lower incomes. Child care was also independently related to children's language comprehension. Children who had experienced more positive caregiving and more language stimulation in child care had better scores on language comprehension. Children who had more center-based care had better language comprehension.

In terms of behavior problems the theme is similar. Children who were in better quality child care displayed fewer behavior problems at 24 months than those who were in poor quality care. Family factors and child factors were other contributors. Child negativity in the lab was related to family factors and child care factors. Those with more center experience showed less negativity, as did those in better quality child care.

I began this presentation by noting that low-income families face difficult obstacles in trying to meet their children's child care needs. As we looked more closely at the lives of several families, we saw that the care arrangements were often fragile and transitory, dependent on the goodwill of family, friends, and individual caregivers. Assistance in paying for child care was needed by many more families than were actually receiving subsidies. In the absence of this assistance, families were finding it difficult to sustain employment, although working families were still in poverty.

It is for this reason that the substantial anticipated decreases in child care expenditures for the working poor, $1.2 billion by one estimate, is so worrisome. Also worrisome is the condition of the near-poor, those at 100–200% of poverty. These families have the fewest opportunities for center-based care, relying on grandparent care, non-regulated child care homes, and shift work so that parents can trade off their child care responsibilities. In the face of parents' challenges in trying to orchestrate child care, it does not seem quite fair that the care that they are finally able to get is often lower in quality than that used by families with higher incomes. This discrepancy is evident in a variety of settings, including care by sitters, child care homes, grandparents, and fathers. The quality of center-based care is also likely to be problematic when the poor are in nonsubsidized centers, as are many of the near-poor and working class families.

These quality differences do not bode well for the development of low-income children who experience poor quality child care in disproportionate numbers. In the NICHD study, I remind you again that children who were in poor quality child care across these different settings had lower scores on cognitive and language assessments, even after controlling for family factors. Poor quality child care was also related to more behavior problems and lower social competence.

By the same token, the good news is that these findings demonstrate the potential of high-quality child care and center-based care, as well as stable child care settings to support children's

development. At a conference devoted to creating a shared agenda to improving the lives and the development of low-income children, the take-home message is a clear one. Child care matters for children and for families and we need to ensure that their child care needs are met.

Hagen: Rather than try to provide a discussion of the two presentations, which I think were very complementary and provided us a wonderful set of issues to be considering on this, our final day, I just wanted to comment briefly on three ideas.

It occurs to me as I hear both of these presentations that many of us here spend much of our time doing research on basic issues in development: early cognitive development, perceptual development, and affective development. Yet, do we account for what Danziger and Vandell have told us about—do we have any idea what kinds of child care arrangements and how many different child care arrangements the children we see in our laboratories have been exposed to? Those of us who spend a lot of our time in the research lab need to take to heart the lessons we learn from these presentations.

It also occurred to me that we do not know what life has been like for these children and families over many decades. There may be no way to really know this, but perhaps some of our historian friends like Maris Menoskis, who has been to this conference in the past, can give us some insight. Was this situation better for many more children in the decade we always glorify, the 1950s? What was it like in the 1930s during the Depression? What were the arrangements then? That is something we should consider as a topic for future conferences.

My final point is that over the last several days I have seen interrelations among what seem like very different topics and different considerations. Ed Zigler is going to pull that together for us in the final session, but in particular I recall Robin Karr-Morse's presentation on brain and behavior. Usually when talking about brain and behavior, we are talking about links between early perceptual motor development, then, later, cognitive and language development. Karr-Morse's presentation in particular talked about the impact on social-emotional development, indicating that children were programmed early with a fight-or-flight response. I found that very interesting and very sobering. I have worked with older children with different types of learning disabilities and problems such as attention deficit disorder. She used that as an explanatory mechanism, that these children are learning to adapt in appropriate ways, given the situation that confronts them. Thinking about what these children are learning about self-efficacy, given their parents' situations and lack of feelings of control over their environments, it seems to me that we have very challenging new ideas that we have to incorporate into our thinking.

For those of you who are working day-to-day in Head Start programs and settings, certainly these issues are very important. The children in Head Start are there for a few hours a day, 5 days a week. Most of their time is spent in other arrangements and often we know very little about these arrangements. Yet, we now have more and more evidence that these arrangements are, in fact, making tremendous differential impacts. Danziger referred to the Sameroff additive model—a deceptively simple model—which has been shown time and time again to be very powerful. It seems that children and families are able to tolerate one or two risk factors, but when they are exposed to more than one or two, then they are past the threshold. We are now finding that model also works in many of the physical and biomedical areas when talking about physical and health risks. Certainly as we get more into the socioemotional and cognitive areas, we have more and more evidence from different camps that these are highly important.

Again, I want to thank the speakers. This was a wonderful session that begins to pull together a great deal of information and gives us challenges as we now start to think and plan for our direction to continue the progress at future Head Start conferences as well as in the other professional spheres of our lives.

AUDIENCE COMMENTS AND QUESTIONS

Comment/Question: I was glad to hear that 50% of the Head Starts are now full-day programs. I am more aware of the problem that Head Start programs have in finding enough people whose income qualifies. In New York, this is a particular problem because the income qualification is $12,000. If people are being asked to work, how can they have children in a full-day program if the income qualification is so low? Is either of you aware of any changes that will be made in the income qualifications?

Hagen: Is anyone here able to answer that? Our presenters say they are not sure. I think you are raising an excellent question. It is mind-boggling when one thinks that when one's child is 12 or 13 weeks old, suddenly one is supposed to be working at least half-time. Often it is not just one child; there are other children that the parent has to consider.

Comment: There is an incredible contradiction involved.

Comment: The prospect of welfare mothers earning more than $12,000 is not very good. If one works full-time year round at the present minimum wage, that is 2,000 hours at $5.15 an hour, they would still qualify for Head Start. My point was that welfare reform neglected the economy. Welfare reform and Head Start have not been linked together enough and linking is needed now that welfare mothers are expected to work full-time, year-round. If one wants them to support themselves above the poverty line, they will need more than $12,000 to do that, which may require a change in the minimum wage.

Deborah Vandell: The other part of it, of course, is that child care costs are substantial. We need to raise the cutoff for Head Start. Subsidies need to be significant subsidies that continue after mothers earn more, because the cost of care is so substantial. This situation means that one cannot actually work and pay for care.

Comment: In a cynical state of mind, wouldn't the government be smart not to raise the income qualifications and phase out Head Start over the next number of years, and take yet another entitlement away? That is cynical, but with a sympathetic audience, it is appropriate to mention.

Comment/Question: I was interested in Danziger's comment on Canada's child poverty rate, and the comparison of America with other industrialized countries. I worked at Head Start. I now live in Canada and we are not proud of our child poverty rates. They are not that much lower than the U.S. Both the U.S. and Canada have much higher child poverty rates than European countries. I am reflecting on a combination of things: the child care patchworks that many families have to put together, the number of patchworks that people in child care and Head Start are doing, working around what seems like an irrational approach to the well-being of children and families. I wonder if people in this room are interested in a more broad-based perspective, rather than just children who qualify or who are low-income?

Danziger: My positive statements about the child poverty rates in Canada are based on international data using comparable measures, showing that Canada's rate is 12% while our child poverty rate is about 20%. Northern Europe would be at 6%. You have your own measure, which is different. I like to use Canada as an example because everybody is familiar with this picture.

If I map child poverty and elderly poverty 30 years ago in the U.S., the elderly poverty rate was higher and the child poverty rate was lower. The elderly rate has gone down and the child

rate has gone up. If one looks at U.S. children and Canadian children, it is very similar. Canada is a role model to demonstrate how much better things can be. One may look and say that we are not as good as Northern Europe, and that is right as well. However, for the US, if we could get to where Canada is now in 10 years, that would be marvelous.

In terms of the Clinton policy, it is a no-brainer. We have expanded the earned-income tax credit, which is very important because now a minimum wage single mother of two children can get $3500 a year on top of the minimum wage. Ten years ago, the earned-income tax credit only amounted to $600. President Clinton had also talked about making the child care credit refundable. Of course, we cannot do that, though, because we would then have to cut the capital gains tax. Again, as a no-brainer, a child care credit is a very simple way to put more money in the hands of low-income people without worrying about where to set the threshold for care or for eligibility.

One has to look beyond child care. In this case, we need to look to something in the tax system, and it would be simple to have this credit. Certainly when my children were young, I filled it out and got a credit. It is ridiculous that high-income people get the credit and low-income people do not.

Comment: I thought it was only about $100.

Danziger: The maximum credit is $960 for two children, at the top of the schedule. At the bottom of the schedule, it is as much as $2400. The amount to be subsidized ought to be raised. However, at a minimum, if it were refundable, if all one did tomorrow was change one word in the tax code, then low-income families would get $1000 more then they now receive. I do not disagree that they should receive more, but that would be a relatively simple place to start.

Comment: We have heard from a number of speakers that the message coming from employers is that they want workers with more skills and more training. I wonder if that message should be examined a little bit. I am involved in a study that is listening to what employers say they need from new workers. What seems to be missing from that is, where are the jobs? The request for a greater level of skill is possibly a screen for the absence of the jobs. I am thinking specifically of the use of technology that requires the replacement of jobs that are not actually highly skilled. To book tickets on the Internet, a point-and-click, is not the same as the deep knowledge of a travel agent in many different airlines and hotels.

In the study in which I am involved, people graduate and go into the medical technology fields where machines are completely automated. I would like to raise the point that the demand by employers for skilled workers is in part not supported by the types of jobs in a highly technological field. The work is relatively simple and the employees do not need very much training because much of what they will do is use point-and-click and touch screens.

Danziger: It is right that the skills we are talking about for low-wage workers are not high-level skills. However, they do demand simple reading, writing, and the use of keyboards. For example, in our study, 11% of mothers receiving public assistance said that they have trouble reading newspapers and recipes. It is unlikely that a firm that needs employees to watch gauges or point and click is going to hire somebody with those reading skills. I want to say that the difference between old line industrial needs, when one needed a strong back and the ability to show up and follow instructions, and today's work environment is substantial. Many employers have requirements that many public assistance recipients cannot meet. Holtzer is redoing the earlier study to see which qualifications employers are willing to loosen in a very tight labor market.

Technology continues to allow labor-saving devices. To be a receptionist today, one must know how to use e-mail and how to use a fax machine. That is not highly complex, but for a high school dropout who has never seen a fax machine, an employer must take the time to train them. If employers are not willing to do that, then one has a skills mismatch.

Vandell: Due to time constraints, I did not mention in my talk the description of efforts to move families from welfare to work. Case studies in Wisconsin that are consistent with formal and informal surveys around the country indicate that about 50% of the families with child care assistance are making the transition to work in the first 2-year period.

The 50% who are not making the transition so well are like one of our case studies, Sandy Sears. She dropped out of high school in 9th grade and cannot read. She participated in the Learn Fair Program in Milwaukee for a while, but she left that and we lost track of her. I think the computer screen would have been difficult for her to master.

Comment: I would like to share with you briefly an illustration of how both employers and employees can mutually benefit each other. For many years, I have been on the board of our local Humane Society, a private, nonprofit entity. We have had a terrible problem of employee turnover. Most of our 30 positions are fairly low-level, and as McDonald's and Burger King raise their minimum, we were losing people to places like that all the time. Last summer we decided to raise our minimum from $5.50 to $7.00 an hour. We also have worked with a consultant to make it possible for people to move up the career ladder.

Our annual budget is about $900,000, and the increase in wages is costing us about $25-$30,000 more a year. It is the best change we have ever made. We have gone from way over 100% turnover per year to a turnover rate of about 25-30% right now. We have employees who start at $7.00 an hour and, if they do well, can move to $8.00 or $9.00 an hour. If an employee gets up to $9.00 an hour plus benefits, that puts them well above the poverty level. Employees' views of their jobs have improved. This has proven to be a win/win situation, and yet we did not have to materially increase the job skills. We have an adequate variety of skills. Several of our workers have very low literacy skills, and yet they are wonderful employees, and they are valued there. I do think that there are a lot of innovative ways that can be beneficial for both employers and employees.

Comment/Question: My husband and I are both professionals, and yet the thought of starting a family and paying for child care is very daunting for us middle-class families as well. Our country also has to look at that, and I would hope that we would be pressing for help for middle-class families as well. I know a family where both parents are working but they have to do shift work because they have three children and cannot afford quality child care. The low-income families at the poverty level receive quality child care or better than they previously had, and very high-income families receive quality child care. What about middle-income families and the working class? Those families are hurting right now.

Vandell: Actually, almost everybody is hurting. It is interesting, because we had a comment earlier that there is not a coordinated, organized, concerted policy related to child care. It is a peculiar kind of situation that I keep thinking optimistically is going to change. Then I read a survey where some people say that child care is the business of individual families, and other people do not have any business being involved with it.

Yet the majority of children in this country are in child care, and child care is a challenge for almost all families.

My dream would be that child care would be an entitlement in the same way that public education is for school-age children. I think that the push has got to be in that direction, because there are too many people struggling with child care on a daily basis, and because it is not actually limited to any one small segment.

Hagen: Thank you again to our panelists. We especially appreciate that they were able to fill in so wonderfully for Aletha Huston who could not be here.

Evening Workshops

Developing and Sustaining Partnerships Between Practitioners and Researchers

CO-CHAIRS: Hiram Fitzgerald, Faith Lamb-Parker
PRESENTERS: Hiram Fitzgerald, Velma Allen, Barbara Garrett, Richard Gonzales, Faith Lamb-Parker, John Fantuzzo, Daryl Greenfield, Irving Sigel

Hiram Fitzgerald: My talk is about sustaining a partnership with our first partner, Mott Children's Health Center. We have about 20 partners in applied developmental science graduate programs at Michigan State University. Applied developmental science has three main objectives: to facilitate university-community partnerships and introduce affiliations; to emphasize the integration of theory, research policy, and practice; and to address issues of concern to the community that enhance university research and training programs.

We conceptualize the model as starting with community organization. That means that in our program we do not deal with problems that are not defined by the community. The community comes to us in a variety of ways and presents a particular kind of problem, a particular set of issues. We then try to find faculty or staff at the university who might already be skilled in the content area related to that problem. Therefore, if it is a child-abuse problem, we look for a faculty member who is already doing child-abuse research; if it is a problem having to do with economic development, we go to faculty who are already addressing economic-development issues; if it is an infancy or early childhood issue, we go to faculty in that field; and so forth.

We then try to form a partnership-management team—at the administrative level—represented here by Velma Allen and myself, and involving Mott Children's Health Center and Michigan State University. It is the function of the management team to oversee what we hope will be a successful marriage between faculty and the community staff. If that is the case, then the applied developmental science management team turns it over to the faculty, and it becomes their project, not our project. We continue as the management team to oversee and help put out fires as they develop. If a problem comes up, it might come back to the management team. We help to solve it, and it goes back into the faculty-community loop. We run a kind of brokerage firm to help link faculty and staff to the community and to oversee the development of that partnership.

A first step in the partnership process is to develop a mission statement. For example, the initial mission components for Mott Children's Health Center and applied development science involved technical assistance, demonstration projects, graduate and professional education, and the expansion of programs. These are expansions of Mott's programs, not our programs. That led to four focal issues that Mott defined as important for the community in which they are situated—Flint, Michigan: (a) school-based, comprehensive neighborhood services; (b) enhanced, community-wide services for infants, children, and youth; (c) youth violence prevention; and (d) the promotion of healthful behavior among youth.

In the midst of all of this, we had organizational changes. The vice president of Mott, with whom we had initially worked, left and was replaced. The Mott Children's Health Center underwent substantial organizational change in its structure and in its function. At Michigan State University, the vice-provost who helped initiate the initial collaboration left and has been replaced. For us that meant a change from a supportive, administrative person who operated largely at a philosophical, educational-theory level to someone who is very product and task oriented. Since we are also product and task oriented, this change was actually good for us. We now actually get decisions in a short period of time without a lot of philosophical debate.

However, what enabled our partnership to survive as we went through these changes may be tied to five key points. First, we have a commitment or a responsibility at the institutional level to the partnership. If any faculty member leaves a project, that is not going to imperil the institutional commitment to our mission statement. The mission statement then serves as a hub that sustains the partnership even though people come and go. It seems that as long as change does not damage the mission statement, the statement is able to carry us through.

Second, we accept community scholars and university scholars as equal with respect to their unique knowledge base. Community scholars are all the people who work at Mott Children's Health Centers. They know the clientele and the problems they are dealing with. The people at the university do not. University scholars have scientific knowledge and skills. This gets us out of the scientist/practitioner distinction. That leads the group to an outcome-oriented work plan. Scholars bring to the table their respective knowledge about the problem area. They ask, "Can we get to a better evaluation design in 2 years by tweaking what you are already doing that might answer your questions a little better? What are the problems and issues that we have to deal with in order to get there?" We also are committed to shared scholarship. All of our partners have the option to present at conventions or share publication to the extent that they wish to be involved with those processes.

Third, we recognize that community-defined problems most likely require long-term commitments. We are not interested in people who approach us for short-term, quick and dirty evaluations. We also are not interested in people who approach us for service. Others can do that. We are a scholarship-based graduate program and we bring scholarship to these commitments. This involves shared resource development and long-term commitments.

Fourth, we recognize that partnerships are dynamic and require constant monitoring, flexibility, and tolerance. We accomplish this through the administrative management team.

Fifth, we recognize that partnerships involve many stakeholders and that these stakeholders have to be part of the information network as well as contributors to the partnership. We accomplish this through something we call "program policy rounds." Periodically, once or twice a year, —it varies for different programs—we bring all the people involved together: the funders of community-based services and leaders from the community. We make presentations about what we have learned in the past year in the particular project, the results, and where we think we need to go in the next year or two of the project. We get their feedback about design issues and about whatever other issues they want to bring to bear. Then we incorporate these ideas into the planning process.

Finally we recognize that other communities may benefit from lessons learned of both successes and failures so we ask our community partners to commit to cross-site linkages. For example, we took the evaluation of the neighborhood Teen Health Center and linked those people with a comprehensive health service in Grand Rapids. They began to exchange ideas. At first, neither knew of the other's program. That linkage has led to a continued dialogue between those people.

Velma Allen: I am the point person in the partnership just described by Hi Fitzgerald. I will begin by telling you about the health center. We are a private not-for-profit organization that provides health care to low-income children and their families in Genessee County. Our mission

is to make sure that we are looking after children who are unserved or under-served. That is where we dedicate our resources. We do not want to supplant someone else who may be taking care of an issue.

We need the university in ways that we might not have felt we needed them in the past, and the onus is more on us now to try to work with them. At the beginning, I will admit, we thought, "Oh, here we go, somebody wants to get tenure so they are going to study us. Then they will take their little study and go back to the university and we will be left doing what we were doing. On top of that, they will be interrupting our good work!" We had to do some work on these attitudes and develop a healthy respect for each other's work. Now we know that we do need each other and we are going to see the partnership grow.

Barbara Garrett: Collaborating and forming partners in the community with Head Start ensures that children and families receive the highest level of services. Collaboration also helps foster the development of trusting partnerships with families. Often a community that shares responsibility fosters the healthy development of children and families of all cultures.

At the university, there have been several research projects that were completed and were very valuable to parents. However we need to continue to work on bridging the gap between researchers and practitioners so that we can make a significant impact on our community. Practitioners need to ask researchers more about how to do things and how to ask questions. I feel that when researchers come to the program, the parents do not always ask enough questions. Thus, we are trying to form a partnership where parents may feel more comfortable. The university in our community has a richness, diversity, creative energy, and enthusiasm that enable them to be advocates in addition to partners. We need to work together so that we can put our findings into an action plan that will enhance the quality of life for our communities.

Starting in September, we formed a partnership with Children's Hospital. They will be sending residents to spend half a day in the classroom working with children 1 week and half a day interacting with parents the next week.

Richard Gonzales: We are the largest grantee in the country with 72 delegate agencies (about 215 centers), serving nearly 19,000 children. We just are about to award expansion money to serve another nearly 900 children. I wanted to give you that context so that you could understand some of the issues we are talking about.

About 2 years ago, our agency along with Columbia University School of Public Health applied for one of the Head Start/University Partnership Grants. We received the funding for what we think is a fairly extensive project. I am only going to briefly describe it because what I want to focus on are some of the issues that came up in trying to bring researchers, practitioners, and parents together to do the planning of the project.

The purpose of the study is to look at how communities may influence the effectiveness of Head Start. For the first time we were going to share data: The public schools had information on children, the Department of Health had birth certificate information, and Head Start had information. The Department of Health had data on children born in New York City; birth data and risk factors of children at birth. We also had the reading and math scores of children who had gone through the school system through the second grade. What we wanted to do was a three-way match to see which children had passed through Head Start programs in New York City and for what period of time. Part of the purpose of the study was to see if the three bureaucracies could share information and provide data to each other.

Interestingly, at the time that we were applying for this grant, I had been speaking to the Head Start delegate agency directors about the importance of doing research and getting involved in it because, although we were the largest grantee in the country, we had not done any previous research. We all saw this lack of research as a major problem, and so everyone agreed that going for

the grant was a wonderful idea. We needed to do it; we applied; and everything was fine. However, our first mistake was not sitting down to get the buy-in from everyone of exactly what we were going to be researching. We felt that certainly everybody is excited about research, so it almost does not matter what we do because we are just getting started, and it is a first step.

When we got the grant, we called the delegate directors in and talked to them about the data we needed from them. We told them all about the research project and let them know that we did not need a lot of information from them. What we needed to know was what children attended their program between 1991 and 1994, their dates of birth, and how long they stayed in the program. Well, I am sure many of you might guess that the reaction to that was not as friendly as we thought it would be! In fact, I received a letter from one Head Start director who compared me to Hitler and decided that I was beginning to try to control the lives of families.

Another issue arose. Many directors felt that we needed to go back and get the individual approval of every parent who had been in the Head Start program from 1991 to 1994. Then I would say, "But wait a minute. We are not looking at any information about these children. All we are asking for is their date of birth and if they went through the program." It still did not seem to matter. So the first thing we knew was that we had some educating to do. We realized we might have to take a step back and start a bit differently. So we did. We had formed a partnership with Columbia from the start. This was a decision-making group representing the grantee administration, directors, education directors, family services coordinators, parents, and researchers. This time we came together to discuss how to best explain the project to the full New York City Head Start community if we were going to move ahead with the project.

One of the things we created from the beginning was a plan to meet and discuss any problems that might arise as we conducted the project. We recognized that there had to be a sensitivity to issues and to differences of opinion because we saw that we were going to have a lot of that. In addition, we had decided that participation in the project was voluntary. We were not going to mandate programs to share information. As the partnership team talked together, we realized that there were differences in language. How we were using the same terminology was different. We had to define common goals. Why were we doing this project? What did we hope to find? People were very concerned that in doing this project we might come out with negative results that would hurt Head Start. Had we given enough thought to the process of what it was we were going to be looking at? In addition to creating a bond of trust or the beginning stage of trust, we also were looking to create common priorities and common policies, and confidentiality became a big issue. Therefore, we spent a lot of time talking about how one shares databases; how information really is not information; how it gets translated into coded numbers; and those coded numbers become part of what gets matched so one no longer has the names of children and the dates of birth of those children, but rather the matched data without identifying information on particular children or families. Most of us in the Head Start community did not know about these complex manipulations of information.

Now we are in Year 2 and we have, in fact, collected a lot of data. About two thirds of the agencies or sites that were in existence at the time have agreed to participate, and at the present time we have data on about 10,000 children. So things have started to come together. We have the benefit of Columbia University students to assist in data collection. They have been contacting the programs and saying "If you show us where the files are, we will help you go through them, and sort out the names." Since the staff is generally overloaded with their daily tasks, this was not their priority—to be looking at data that went back to 1991.

We are now approaching the point where we will be analyzing the data. Now we have a common vision and shared decision-making as a part of our ongoing process. All decisions made by the team are consensus decisions. It may take a little longer that way, but it is building up a certain kind of support and trust that actually makes it easier to move ahead. There is a real respect for individual differences, a recognition that we will not always agree on all points and that some things can be put aside. Barriers are being identified ahead of time. Actually there

were several times during discussions when we sensed that there would be a problem. It would have been easier to just avoid it because no one was bringing it up, but we realized that that was not the way to go. We needed to bring up the problem and put it on the table, seek out the problem, and then address the concerns. We also needed to define the roles of the various members of the team and the time frames and how we were going to support one another. For me, this was a really important process in getting started.

Since that time, we have actually begun another research project with a small cluster of agencies in Manhattan. We have begun to look at other ways to introduce Head Start staff and parents to research and its value to them, how to not be scared with the process. Certainly knowledge helps us to overcome those fears.

Faith Lamb-Parker: John Fantuzzo, Daryl Greenfield, and I have been involved in ACYF-funded Head Start/University partnerships on and off since 1990, and we have been thinking about the fact that no one had been looking at the process of what we are all going through: the partnership process. Therefore, we decided to study this process. We collected all of the funded ACYF grant proposals, beginning in 1990 that required partnerships between university researchers and Head Start. That included: about 20+ Head Start/University Partnerships; 31 local sites for the Transition Demonstration Project; 4 Quality Research Center grants; 16 Early Head Start local evaluations; and 2 Correlate Studies.

Along with Cheryl Clark from Ellsworth Associates, we read them all, and looked for issues or themes, strains of what the partnership was all about. To do that, we extracted questions, statements, and phrases from the proposals. We reduced the list, eliminating redundancy, and coded the list into categories. These categories included: level of decision-making; frequency of partnership meetings throughout the period of funding; amount of time spent on various tasks having to do with the project; level of participation in the actual research tasks; feelings and thoughts about the importance of various aspects of the partnership process; level of satisfaction over the course of the partnership; and the personal value placed on the partnership.

The end result was a two-page survey about the partnership process. We sent surveys to 246 partnership participants, including researchers and Head Start partners. These partners could be Head Start administrators, Head Start staff, the liaison to the partnership, and parents, or others who were unspecified. Out of the 246 participants to whom we sent surveys, 134 have responded thus far, a 55% response rate.

Daryl Greenfield: We spent a fair amount of time developing this survey. We started with a whole series of questions, many more than what we ended up with, and we went through a series of iterations. John showed various versions to researchers, Head Start staff, and parents for feedback. One goal was to cut the survey down so that it would be short enough and have enough interesting questions so that both researchers and partners would respond. We want to share one set of results with you.

Question 1 – Rate the level of decision-making for each of the following partners: (a) Head Start Director, (b) Policy Council Representative, (c) University Researcher, (d) Participating Head Start Staff, and (e) Participating University Research Staff. In a sense, this question gets at the essence of the beginning of building capacities with a partner: being able to communicate and share decision-making. What we wanted to analyze initially was whether there were any effects of actually being able to carry out the research projects related to partnerships where there is shared decision-making. In order to figure this out, we took a mean summed across the five parts of Question 1. What we used for each partnership is a score that represents the partnership's shared level of decision-making. Partnerships where there were fairly high scores from everyone, indicating that most everyone had a chance to share in decisions, would end up getting a high mean score, and those that had only a few people making decisions would have a low mean score.

The first thing that we looked at for these two groups was the level of participation in the actual tasks of the research project. Those are found in Question 4 a, b, c, and d which delineate the basic tasks involved in setting up a study, in making decisions of how to recruit subjects, in getting involved in recruiting subjects, and so forth. We found that where there was a high level of decision-making among participants in the beginning; there ended up being high levels of participation in carrying out the research tasks. These were all statistically significant.

John Fantuzzo: There were a number of statements that we found across the different proposals. We developed those into Question 5. When we looked at Question 5, we saw an interesting pattern between the high-decision group and the low-decision group that was statistically significant. The following are examples. In 5e (Roles of the partnership members regarding project objectives were vague and ill-defined), those who had reported lower levels of shared decision-making were significantly higher on that than those reporting higher levels of shared decision-making. In 5f, (There are factors that inhibited the partnership process), those with lower levels of decision-making were significantly higher in reporting that there were factors that inhibited the process. In 5k, (Participating in the research activities contributed to the professional development of members of the Head Start staff), the high-decision group reported that there was greater participation, and that supports what we found in Question 4 where people who had higher levels of shared decision-making actually reported participating at a higher level. Those who reported higher decision-making reported a higher level of the partnership contributing to those kinds of services.

Question 3 asks to indicate which of the following percentages best represents the amount of time spent on the various tasks at partnership meetings during each year of the project. The results support what Richard Gonzales shared with us. He told us about what happened in Year 1 and Year 2 of his project. What we did was to look at the pattern in Year 1 to see if there were any significant differences between the high-decision group and the low-decision group on how they reported spending their time.

In Year 1, we found that the high-decision group was spending significantly more time on issues related to protecting the rights of participants and discussing issues of cultural sensitivity and value. The low-decision group in Year 1 was not spending as much time on these issues as the high-decision group was. You may now draw some interesting conclusions from what happened in Year 2. If you look at Year 2, at how people report spending their time (just like Richard Gonzales just shared with us), they are talking about how they are going to select measures and collect data, and they are spending additional time talking about continuing a dialogue about protecting the rights of participants. The low-decision group was spending significantly more time on barriers to project objectives. Therefore, in Year 1, for the high-decision makers, spending more time talking about participants rights and issues of confidentiality, issues of sensitivity to the relationship, and sensitivity to cultural issues enabled them in Year 2 to spend more time on the actual research measures, questions, and analyses and less time on talking about barriers to project objectives.

Overall, there were significant differences for Question 6 and Question 7 between the satisfaction of the research and the value of the research that supports this information. Interestingly, the group that reported more shared decision-making also reported greater satisfaction with the research and the research products. What is of interest to us is that if one is thinking of a kind of desirability report—that only 60% of the people responded—we have variability and, if people on a self-report measure report honestly or try to report as positively about their partnerships, we felt that both the Head Start administrators and the researchers were really presenting an accurate account that fits with some of the information that we have from actual experience, and with the literature on shared decision-making.

What is nice about this is that it shows that these issues could actually go into our training and inform researchers about how to work with the community so that they do not have to have

big bumps in the road. They can start working on these issues right at the "get-go." In addition, it tells federal funding agencies that they need to build in time for these issues to be addressed which ultimately would maximize federal dollars in terms of more productive research and fewer barriers between the researchers and practitioners.

Irving Sigel: What I would like to talk about are a number of issues of concern that are basic to establishing not only a partnership, but any kind of research/practitioner interaction. It is a gap that is considerable. Therefore, the first question that I think we should address is, Why a dialogue? That might be used as a guide. We say a dialogue because we want to share the extensive body of knowledge in early childhood education. There is a tremendous amount of information available. How you distill it? How do you work from it? What do you choose? Who chooses it? Is it real? These are very complex questions.

What you want is to get answers for enhancing programs and guiding educational policy. This is true not only for Head Start, but it should be true for a number of other places too where there is work between researchers and practitioners. After all, many researchers, many universities go into the public school; they give them a song and dance about how their contribution of their time or that of their children will contribute to science. They do the study; they send them a little anecdotal summary, and that is it! So the recipients say, "Why are we bothering with these people?" Then the next researcher comes in and goes through the same thing. Still, there is always hope. They think, well maybe this time it will be different. Then it is not. So it ends up that after a while one cannot get into these schools, and it is not because the practitioners are resistant and uncooperative; it is because researchers are not really fulfilling their job.

Therefore, why a dialogue? To share the extensive body of knowledge in early childhood education; to get answers for enhancing programs and guiding educational policy. Researchers discover information, but are not necessarily aware of its educational value; practitioners do not find research studies accessible.

What issues need clarification to accomplish the goals of a dialogue? One is who decides the problem to study. The researcher often goes to a school and says this is very important in education and we want to do a study—not getting into a dialogue about whether or not the school thinks it is important.

Then, who decides how the research is to be carried out and whose responsibility it is? Since this involves quality control, it becomes, in a partnership, an issue of being informed.

Once the study is carried out, how are the results reported? The answer is, of course, in journals, like *Child Development, Human Development,* or *Educational Psychology*. The journal editors and the authors decide how they are reported; the participants get a footnote: thanks to so and so at so and so school for allowing us to carry out the research. Then the researchers send a copy to the teachers or the principal.

If it is reported that way, it is our own research community talking to itself, which is one of the things that practitioners very often accuse us of doing because the question becomes once the findings are reported, are they accessible? The language of research is not common, everyday discourse. Say it in English! For example, we use the words discourse and interactive—what do they really mean? Is discourse just talking to people? If so, say so! Is it just having a conversation? What is wrong with saying that? Our research reports are rarely if ever communicated into English that is free of jargon. We are the best inventors of jargon. Therefore these results are not accessible. Even if they were to be made accessible, who decides how to implement them?

The whole notion of implementation is a very complicated business. Most of us researchers, with due respect to the present company of course, do not know how to implement anything. How many of us researchers actually know how to work with a group of 4-year-olds and keep them interested, motivated, under control, productive, and active? Chances are we would last about 10 minutes. Implementation has tremendous unique requirements that researchers can only deal with when they interact with practitioners.

What does this require here? If we want implementation, then there are at least two very important areas to consider. One is the notion of change on the part of each participant. Talking at/talking to is not a way to get change. The other is the notion of motivation. What is Hi Fitzgerald's motivation in making himself available to all these people? He is not just a good guy. No, he has an interest that is an open and honest one. He wants to create an environment that could help his graduate students learn how to become applied psychologists. Once one puts that on the table, then there is a difference: there is no hidden agenda and it is not the ego needs of the people involved.

Therefore, we have to be very careful and thoughtful about how we create the process of engaging in a dialogue to create a partnership or a cooperative venture. To get change, people have to be willing to put themselves into positions of some vulnerability, and that is a frightening thing and one to which we need to have tremendous sensitivity.

Retraining is another aspect of how to implement a true dialogue. Along with retraining often comes a restructuring of the setting and resolving ideological conflicts so that the objectives of the research may be met or a mutual problem solved. What we are really talking about now are differing belief systems. We must face up to the fact that we do have differing belief systems that are often implicit, and we do not always recognize where others are coming from. I am sure if one were to analyze my comments, one could find out all the biases that are there. However, if someone asked me, I would say, "There are no bias there. I am just telling you the way it is"

AUDIENCE COMMENTS AND QUESTIONS

Deborah Coates: Did you analyze the data by site?

John Fantuzzo: No, we did not analyze by site. We looked at the individual reporters. Also, we have the data to look at differences between Head Start administrators as a group and the university researchers as a group, but we have not analyzed them yet.

Coates: It seems more important to me to look at groups where there is a high contrast between how different people who are playing different roles at a particular site view their decision-making, so that one could see where people had a shared view of decision-making. For example, administrators, parent policy council members, and researchers all saw their decision-making roles as high. That would be very different from if researchers saw their role as high and administrators saw their role as low, or vice-versa, where the administrators thought they were making all the decisions and the researchers felt that they had no say. Actually, one would not have to look at the data by site, just by roles.

Daryl Greenfield: There are clearly many things we can do with the survey, and not all of them have been returned. We thought it would be interesting to look at the whole group first, not that everyone agrees, but everyone has a role in the decision-making. We thought it would be an interesting comparison to look at, given where we are. The data are not all in but we wanted to have some preliminary analyses to share.

Coates: What were they making decisions about? Was it strictly about the research or was there continuous program improvement involved?

Fantuzzo: What we tried to do with the survey was to create something short enough and simple enough so that people could understand the nature of the questions and it would not be too burdensome to fill out. We tried to get at the kinds of issues people discussed in their grant proposals of how they would conceptualize and carry out the partnership. We also included the

kinds of issues that Head Start had written in the RFP.

Therefore, for issues related to partnership one would want people to be able to share decisions. We have information on the tasks. What were the research tasks that the Head Start staff was involved in? What sort of things occurred by year in terms of issues related to research questions, cultural sensitivity, conflict resolution, and so forth?

Then we completed a conglomerate of issues that people brought up in their proposals about the nature of how the partnership evolved and some of the issues that were discussed in planning and implementing the partnership. Then we had simple questions relating to how satisfied people were and how much value they put on their work in the partnership. There were obviously many more questions we could have asked. We started out with a questionnaire three or four times as long, but it is impractical to ask someone to complete three or four pages. It is unlikely that it will be returned.

Comment/Question: However, in terms of the questionnaire, although I hear partnership all the time, only about 130-odd of the 240-odd questionnaires that were sent came back. That is a 55% return, but at the same time 45% did not return the questionnaires. Did you have a bottom line in terms of the research? If you had a 10% return, would you still have gone forward, and would the graphs remain the same, and so forth?

Fantuzzo: First, this is a work in progress so the information is still coming in. However, if we just look at your position, it is actually a good position. Sometimes the missing data are more important than the data that come in, but in this case, if the conclusions were that everyone is really happy with research partnerships, then your comment would be well taken. That is, maybe the people who are not happy and were not satisfied did not return their survey. The fact that there was variability on a self-report provided by people where everyone was funded to create a partnership was interesting in and of itself. Of course, some people took the time to respond to the questionnaire and some people did not do it in a timely fashion.

We are talking about the data that did come in. We are looking at the variability among that data, and that data showed differences among the groups. What we were sharing is the information we have so far from the 55% who returned their surveys. We looked at the variability in that information related to some of these important concepts. When one sees some differences, that is informative. It is not conclusive. Also, it supports the anecdotal information about those experiences of the importance of shared decision-making.

Comment: Your question illustrates a dilemma that I experience as a researcher. I think your question was "what does it mean to have 55% of the surveys returned?" Does it mean this information is true or suspect? I have worked in a couple of partnerships now where we get the results back and they are always muddy; nothing is ever clear from the point of view of a researcher. You do not want to present your data and say, "We looked at this about 50 different ways and we think it could mean four different things, and we are trying to sort it all out. I guess we have to do another study." I want our partners to understand what some of the dilemmas in our methods are and why they are imperfect, and what you can learn and what you cannot learn. I want to engage in that kind of dialogue with my partners, but that is hard to do. I am asking other people in the room or on the panel how to teach our partners about the dilemmas of the research methods that we use. How do we work with people so that they know what we know when we get the results back, and how can we help them understand our dilemmas?

Hiram Fitzgerald: I think one way this can be done is by involving them in the process, such as in the process of selecting tools; explaining to them along the way your reasons, hear what they have to say, and then work it through with them. Another thing is to listen to how much they really want to know. They may not want an introductory course in methodology; but they may

just want their immediate questions answered. If they have additional questions, they will keep asking them if they are engaged with you in the process.

Irving Sigel: I can illustrate that with an anecdote. We had a dilemma. We planned to develop a questionnaire for parents instead of an interview because funding was an issue. So we developed a fancy questionnaire and we thought everything was clear. We had a focus group of 12 people who could help participate in the process of decision-making around the materials. We gave them the questionnaire and asked them to react to it. Their response was overwhelming. They told us basically that our questionnaire was asking for information that was important only to us. We thought that the questionnaire was addressing important issues, but they thought that these were not important issues for them. We then needed two or three focus groups to deal with the issues that were raised and to help in providing a way of approaching our differing agendas.

It shifted the whole dynamic of how we began to work. The one question was very revealing. Whose problem is it? Is it yours or ours?

I have found many times that there is some aspect of the research project that you do not want to do because it is not what you had wanted to study. However, if you are interested in gaining cooperation from the participants, and you are really responding to them, you may have to do it.

Richard Gonzales: In the project that we were doing, one of the issues that came up was confidentiality. Many Head Start providers just could not understand how information would be collected from the different data sources at the Board of Education, Department of Health, and in our own program, and could be shared in a way that would insure that the participants names remain confidential. Our partners at the university offered to take us through the process of how data are shared and how they are merged; how data get changed to numbers, how the strings of numbers mean certain things, how certain numbers break off and the information disappears, and so forth. At the point where the answers to questions satisfied the group, we were able to move on. That is the process we have used from that point on. As we come up with an issue or someone raises a question that seems to need further educational clarification, we ask the group if they need to take time out for a session on the topic in question.

I would like to suggest that there is a back and forth process. Most difficult for the provider is knowing what questions to ask, especially initially. Staff may feel that they do not know how to ask an intelligent question, or that it is up to the researcher to decide because this their area of expertise. What becomes important in the partnership is for the researchers to establish from the very beginning that we are all scholars. We all bring our expertise to the table. So ask your question. It will be the responsibility of the group to frame that question differently if it is not understood. First, we struggle with the questions until we get a better understanding of what they are, and then we struggle with trying to find the answers.

Faith Lamb-Parker: I would like to add an anecdote. We had two parent policy representatives on our partnership. Robert was a very active participant who was very concerned about confidentiality and asked many questions. In the middle of our third meeting he said, "Let me get this straight. Are you saying that this is not an advisory committee? Are you saying we are going to make decisions?" Even though we had said it at the first meeting, it took him three meetings to believe us—that we were actually going to consult with him, that we valued his opinion, that we were listening to him, and that what he had to say was important to us. I would advocate to be patient. Just because you say it does not mean people really believe it. It has to be a process, a trust being built, a breaking down of hidden assumptions that everyone brings to the table.

Comment: That is so important because historically there has been suspicion, sometimes justified, on the part of both Head Start staff and parents that they are going to be manipulated

and used in a research project. The only way this can be addressed is through joint decision-making, joint planning, and joint understanding. I am pleased to see that it is happening.

Comment: It also would be handy for us as practitioners to come to the researchers with a problem in the community with which we would like their help. Turn it around so that the dialogue can continue to enhance both researchers and practitioners.

Fantuzzo: That is a critical point. Even before you talk about sharing ideas in a decision-making process, it is important to identify some shared passions, and those shared passions could actually create the context for shared commitments. When we sat down with parents and talked about concerns, when people got a sense of what our commitments were to the children and to the families, that really changed the nature of the research dialogue. It also changed the dialogue when my research students spent time in the Head Start centers and were on the floor playing with the children and participating: brushing teeth and changing diapers. Parents saw people caring for people. Then there was a place to starting talking about what we wanted to do.

Coates: The problem I have is negotiating relationships with communities within the university setting and finding support for it. I still do not understand how one actually negotiates these kinds of relationships. There seem to be many researchers who have skills that they can offer, but there are enormous numbers of problems in the communities.

Fitzgerald: For the partnership that we represent today it took about 6 months to develop a mission statement. We held numerous meetings so that we could build trust between all the people at Mott Children's Health Center and the people who represented Michigan State University. We had to get through jargon. We had to get through our saying, "We do not do that," and Mott saying, "but that is what we want." Partnerships come about in all sorts of ways. I did not mean to imply that the community has to come to us when I said that we address community-defined problems in applied developmental science. We can go to the community, but when we go, we are asking them what their needs are.

Velma Allen: Prior to the formalization of the partnership with Michigan State, we did have a specific need. Our board had decided to fund a grant request to do a project with teen mothers. The board agreed to fund this project for 5 years and insisted we find somebody to do an evaluation. We approached Michigan State University. In that situation, a need was identified. We thought we had to put money toward it because we did not believe we could ask Michigan State to fund our research, but we thought they ought to contribute. We felt that there was going to be some benefit to the researcher too. We were able to work out a nice arrangement where we did not think we were being overcharged and the researchers got what they needed. This is another example of how we have tried to find ways to share our common goals.

Fantuzzo: Not all people within the institutional structure are open to partnership, but they can be found. What we have been trying to do in Philadelphia is to create a relationship between Penn and the school district of Philadelphia, not necessarily always in the context of research, but also in the context of teaching. We had to find departments willing to support faculty using graduate courses to create experiences for the community; small programs related to service evaluation. That has been a mutually beneficial situation. Getting universities and the people within the universities to accept some of their responsibility to the community is key.

Gonzales: In New York City, we are hoping to get Head Start programs more comfortable with the concept of research. We have been talking to universities about having graduate students taking research courses conduct a small project in a Head Start Center. This would introduce the

Head Start agency to research and hopefully create a comfort level with the relationship that could exist.

We also plan to pull together various universities in the city that are interested in doing research with Head Start and having a forum to talk about some of the issues that we are concerned about. This type of open discussion that would hopefully generate interest between the universities and the Head Start programs.

In doing both of those things, we are hoping to open up a dialogue that would then lead to new relationships, and even to Head Start programs creating questions for the researcher. The questions need to come from us. The way to get there, we hope, is by creating a more comfortable setting by bringing the two groups together to talk.

Lamb-Parker: There is a great variability in how well partnerships work, even if they are forced. It depends on how people carry them out. One of the first things that we did with a partnership that I developed was to come to the table with the understanding that we all had expertise to share. Given that starting point, we then asked what the Head Start practitioners and parents wanted to know. It turned out that they were interested in learning more about depression: depression in staff and depression in parents. They said, "We do not know enough about depression—what it looks like, where it comes from, how it affects children." So we became a resource to them. Graduate research assistants and I researched it and got articles that we thought were pertinent. When the group met again, we spent part of the time sharing the information that we found. So it became a two-way street: we needed something from them and they wanted something from us. I think that is the way to build trust to further the partnership process.

Question: My question is about statistical rigor. I really endorse the model that you are using for doing assessment and evaluation. However, if you use community participation in forming your questions, and you have to do a large national evaluation, how do you ensure that you are collecting data that is comparable?

I am with Aboriginal Head Start from Canada, and I have the terrible job of organizing a national evaluation of all our Head Start sites. We want to use the community participation model, similar to what you are using. All of our sites are aboriginal, so it is important that we capacity-build in the communities and we also assess what they want to have assessed, but I am concerned because there has to be statistical validity in what we do.

Comment: Understanding what your purpose is and being able to create a dialogue with representatives of that group is where you begin to create the dialogue. It does not mean that researchers must throw away their knowledge base because they are partners. If you want to talk about what we know about child development, we do not start from nothing. However, when you begin to create items for measures, you might have some categories that are informed by the literature that help show you how to communicate with the group. In order to get to the actual items, they first have to understand the categories, and make meaning of them. Then it is about making that understandable to all the groups involved in a national survey. That is how you ensure reliability and validity. If people do not understand or comprehend what it is you want to ask them, you are going to threaten statistical rigor.

Comment: There is one other approach that is important: mutual education; showing people why you have to do what you are doing by helping them understand the logic of it. That is, there is the question of what science is, and what evaluation is, and what rigor is that are not commonly understood.

I would suspect that in aboriginal groups, there is already a great deal of suspicion that what you are going to do is to show how dumb they are. That becomes a sensitive issue; there are

cultural complexities in that kind of interaction. I think that is going to be a much slower process.

Fantuzzo: In some ways too the issue of partnership has to be an end in itself before the partnership can be a means to an end. You must formulate the partnership as an end. People have to see that that is what you really want to do. You want to form a partnership with them and increase communication and dialogue in meaningful ways that will be of mutual benefit, but you have to have a dialogue before you know what will maximally benefit them.

Coates: I just want to say that in my 20 years of going to conferences, this has been one of the most interesting panels that I have ever attended. I think it is because you all have been real, and it is an eclectic blend of practitioners, researchers, and people from different settings. For me it has been a very interesting dialogue.

New Direction in Early Childhood Assessment

CHAIR: Samuel J. Meisels
PRESENTERS: Samuel J. Meisels, Isaura Barrera, Gordon Williamson, Amy Wetherby

■ New Research on Developmental Screening and Performance Assessment

Samuel J. Meisels

■ Improving Early Identification of Communication Disorders: Engaging Parents in the Process

Amy Wetherby

■ Assessing Social and Adaptive Competence

Gordon Williamson

■ Circles of Beauty, Walls of Strength: Research Into Culture as a Protective Factor

Isaura Barrera

Samuel Meisels: Children who are at risk based on screening data go through an in-depth assessment. If that assessment confirms that they have the suspected problems then an Individual Education Plan (IEP) is written. The IEP would be written for preschoolers, or an Individual Family Service Plan (IFSP) would be written for younger children. Then, the IEP would be implemented. This is supposed to be a two-way street so that children who are placed into special education services or who receive some form of special education services are in a process of continuous reevaluation. The reevaluation should result in those children not being abandoned in special classes or in special programs, if that is not necessary.

The Early Screening Inventory-Revised (ESI-R) was something that I began to develop in the mid-1970s. It has been around for a long time and has been published for some years as the Early Screening Inventory. I have recently revised it—re-standardized it—and re-published it. It was intended to be a very straightforward screening, not something that would be terribly difficult to use. Originally, it was published as a 4- to 6-year-old instrument. In part, to make it more relevant to Head Start we added the 3- to 4-year-old range. When we did that, we broke the ESI into two parts: the ESI-Preschool (ESI-P) and the ESI-Kindergarten (ESI-K). It is broken in the middle of the age range so that the ESI-P is used for children 3 to $4^1/_2$ years old, and the ESI-K is used for children $4^1/_2$ to 6 years old.

When reviewing the measure's items, one can see that there are very straightforward sets of tasks. Of course, the items themselves have a little bit more elaboration to them than just jump, hop, and skip. However, the kinds of things we are asking of children are not terribly different from the sorts of things that are assessed with other instruments. We have worked for a long time to develop the reliability and the validity data to ensure that this is an instrument that clearly discriminates between children who are at risk and those who are not.

I want to describe some of our findings to give you a sense of the standardization process. Then I will explain the reliability process and how we validated the instrument. In addition, there are some other criteria that I look for in a developmental screening instrument. It should

be brief; for a 3- to 6-year-old, it should be a 15- to 20-minute procedure. It should be efficient. It should not take a team of people to administer a developmental screening. It should be inexpensive, since the vast majority of children who are developmentally screened are "screen negatives," which means there is nothing wrong with them. It is a preventive step on the part of schools. Schools are the primary purveyors of developmental screening, but schools do not do much prevention. Therefore, it is important that we keep the screening inexpensive and efficient. It should be able to be objectively scored so that wide ranges of people with very different kinds of backgrounds are able to administer it. It should be consistent or reliable. It should be accurate or valid. It should be as culture-fair as one can make an assessment, which is something that is always open to debate. It should be developmental in focus rather than attending to school-readiness types of items and tasks.

The standardization of the ESI follows the following pattern. Everything that I am going to explain will be divided by ESI-K and by ESI-P, meaning first children from $4^1/_2$ to 6 years old and then children from 3 to $4^1/_2$ years old.

For the ESI-K sample, there were 5,000 children ages $4^1/_2$ to 6. They were drawn from 60 sites in 10 states. Twenty of these sites were Head Start and 26 were public schools where there were children with problems. Males and females were equally represented. Thirty percent were non-White and 20% had maternal education levels lower than high school. This was a sample that was not a nationally representative sample. In previous research with the ESI, we put together a nationally representative sample. This is a systematically developed sample, however, that we think reflects the Head Start population.

The sample for the ESI-P was smaller. It is just under 1,000 children, from ages 3 to $4^1/_2$ drawn from 16 sites. Many more of these sites were Head Starts. Fifty-two percent were male in this sample, 47% of the children were non-White, and there was a higher proportion of mothers who had education levels lower than high school (30%).

First, I will discuss reliability. The reliability for the ESI is extremely high. For interrater reliability, we have extraordinarily high exact reliability. The reason it is so high is that the items are easy to administer. In revising the ESI, the actual procedures were put on the score sheet as well as the items themselves. That means that whoever is using the score sheet and keeping track of children's performance will also easily be able to monitor their own delivery of this standardized information.

The reliability for the ESI-P is also high, but the sample is much smaller. Therefore, I cannot feel as confident about it. However, we have not seen problems with the reliability.

Second, I will discuss the validity studies. The way that I assessed validity—and I have done the same in earlier versions of the ESI or with different samples—was to compare the ESI with the McCarthy Scales of Children's Abilities. The McCarthy is a full-scale developmental evaluation that has been around for a very long time. In any event, it is a good test for this purpose. It matches many of the elements and areas of the ESI, but gives a much more comprehensive picture.

In the study, there were 251 children involved in the validity study from a number of different locations. There were several different testers. Everyone who was testing with the McCarthy was blind to the children's results on the ESI.

Correlation coefficients and a variety of other kinds of data were available. They were perfectly acceptable, but they do not tell very much. What do tell you something on a test that is meant to be an identification test are the sensitivity and the specificity. Sensitivity refers to the proportion of children who are at risk and who are correctly identified. Specificity refers to the proportion of children who are not at risk who are correctly kept out of any further evaluation. Therefore, sensitivity is the number of children who are at risk on the ESI-K and the McCarthy over the total number of children who are at risk. That would include the false negatives. We had only 1 false negative out of the 251 children who were assessed on the ESI-K because of the way we set the cut-off. We did have a higher proportion of false positives, but still the sensitivity

and specificity figures are as high or higher than any published numbers for any other developmental screening instrument. Even with this number of false positives, which is where the errors are in the ESI-K, we are still able to achieve a specificity that says that 80% of the children who are screened with this are correctly excluded or are not incorrectly put into an at-risk category.

When the ESI-P was examined, we saw a very similar distribution. It was almost half the size sample, demographically somewhat different. The sensitivity and specificity are virtually identical, however, and again, only one child was a false negative. That means that only one child, who was said to not be at risk, was, in fact, at risk. One has the choice when one does this kind of research to set the cut-off point. We used a model of what is called a receiver-operating characteristic curve to set this to maximize the true positives and the true negatives. The cut-offs can still be moved though. The choice has to be made: Do I want to overrefer or do I want to underrefer? In this case, I would rather overrefer and then warn people that when they use an instrument of this sort, they have to be careful not to create expectations in the eyes of parents or staff that children are at risk when they are not truly at risk. However, I would rather do that than miss some children who need further evaluation.

I am now going to discuss instructional assessment, which is often called performance assessment. In an instructional assessment, the primary focus is on individual learning rather than on group reporting. It is not designed to rank and compare students. Instead, it is a tool for the teacher, and its value is linked to its impact on instruction. It clarifies what students are learning and have begun to master and it provides information relevant to understanding individual students' profiles. Finally, it guides instructional decision-making and provides instructionally relevant information to teachers, so that teaching can be enhanced and learning can be improved.

The approach that I have developed with my colleagues is the Work Sampling System. The Work Sampling System is a continuous progress assessment. Continuous progress assessment is another phrase that can be used instead of instructional assessment or performance assessment. It helps teachers document and assess children's skills, knowledge, behaviors, and academic achievements. It is used with children from age 3 through fifth grade. The relevance to Head Start is that in Head Start there needs to be an evaluation of program implementation and this is the type of assessment that will do that.

The research that I will describe is about children who are somewhat older than the Head Start age range, but I felt that it was relevant enough that I wanted to include it here. I am including the design, some results, and their specific relevance to research in Head Start. This is work that I did with colleagues in the city of Pittsburgh.

We evaluated the validity of the Work Sampling System, a curriculum embedded performance assessment system, as a measure of children's learning and academic achievement. The principal study questions were: (a) Is the Work Sampling System (WSS) a valid means of evaluating student achievement progress? and (b) What is the impact of WSS on teachers and on families?

Work Sampling combines: (a) a developmental checklist that goes through seven domains of development, (b) a structured portfolio of children's work, and (c) a summary report that incorporates data and information from the checklist and the portfolio into something that is easy for teachers to use for discussions with parents, for their own records, and for children's school reports. The study had a cross-sectional design with 345 children 5 to 8 years old in 17 classrooms, kindergarten through third grade. The teachers knew how to implement Work Sampling, so we called them "high implementers." The children were studied over the course of an entire year.

We used teacher-generated student ratings from WSS. Then we compared this assessment of continuous student achievement embedded in classroom work with the Woodcock Johnson Psychoeducational Battery-Revised (WJR). We also used surveys to look at teacher implementation and satisfaction and parent satisfaction. We also conducted 3-hour audiotaped interviews with the teachers and with a sample of non-WSS teachers. We are in the process of analyzing at this time.

The results strongly support the use of an instrument of this sort in kindergarten through third grade among children who are in inner-city schools. The vast majority of the children were African American and qualified for free and reduced school lunches. They were all in Title 1. What we were able to determine is that it is a valid and effective assessment of children's learning. The teachers and families were satisfied with it and that satisfaction increased with more experience with the assessment. Additionally, students made significant achievement gains over time, which is one of the things that we wanted to see happen. We cannot attribute that to the assessment process, because we did not use a comparison group.

The task for me remains to apply this research to 3- and 4-year-olds so that they have more relevance to early childhood and, in particular, to Head Start. One of the biggest problems we would face, though, in mounting a study of this sort in Head Start is the absence of a criterion measure that could be used to compare with work sampling. In this study, I compared it with the Woodcock Johnson, which is an individually administered, norm-referenced, standardized test. It is the best test of that sort given the quality of those tests. However, its validity with young children is dubious because of its lack of relevance to what we are trying to teach younger-aged children. This becomes a wall that many of us come up against. Sometimes we are unable to find criterion tests to validate other instruments because they simply have not been developed yet in the age range in which we are interested. However, I am going to use other methodologies and look at the consequences in Head Start for teachers, children, and families in using this type of instructional assessment.

Amy Wetherby: I am involved in research that is looking at the need to identify children with developmental disabilities earlier, specifically those with communication disabilities. I will discuss this research, the challenge of how to include the family more actively in the early identification process, present some preliminary findings on a new tool that we are developing, and then talk about implications for future research. First, I will present a problem that amazes and shocks me. If we look at the percentage of children that are eligible for special education services at school age, the federal government puts a cap at 12%. However, up to 15% of children have disabilities that may require special education. Now, as we start to think about younger and younger children, we might expect that the percentages are going to be close to that since some of these disabilities are going to show up in younger children. According to data put out by the US Department of Education based on their most current information (1993-94) on the internet, 3- to 5-year-old children receiving special education, which is now mandated for all states, is at a level of 4.4%.

We are now identifying and providing early intervention under what used to be Part H, which is now Part C, for 1.4% of infants and toddlers. So although we are all behind the idea of early intervention, we are missing most of the children. We are not doing a good job and that is the problem that we are trying to address. We looked at the types of disability categories and types of symptoms that are identified in preschool and school-age children, and found that delays in communication, language, and speech are common across most of these. The angle that we are taking is that a more precise way to identify children at a younger age is by looking at their communication development. That is what I want to focus on today.

The brain development that goes on in the first 3 years—the first 2 years of life particularly—is so rapid and dramatic, and language and other skills that are developing reflect that rapid development. The environment has the greatest capacity to influence the child's brain development. We have known for a long time that a stimulating and rich environment is a critically important nutrient for the developing brain.

The following is the research of Hart and Risley who conducted an extensive study of 42 families. They followed them from under 1 year of age up until they were 3 years old. Then they followed some of those children into school. What they found is that the quality of talking the parents do to their children is highly, significantly correlated to the language of their children, to

no surprise. They also found that (a) the child's capacity for learning to talk and the rate at which they can acquire words is practically solidified by 3 years of age and (b) children's vocabulary growth rate by age 3 is predictive of academic achievement through third grade.

Measures that they took in the home included monthly samples from families of unstructured parent-child interactions. They had a wide range of socioeconomic levels. What they contrasted was the amount of talking that the families did. They have a very rich source of data. For families whose parents had professional education, the number of utterances per hour averaged 487. This is compared to the families who were receiving public assistance who were talking to their children but at a much lower rate (178 per hour). That is a large difference. The number of words per utterance also varied. The professional families used 2,153 words per hour. The parents who were receiving public assistance used 616. That is a staggering difference.

Researchers also looked at positive encouragements per hour, such as affirmation-type statements the families were making. The results again revealed big differences. Professional families used about 32 positive statements on average per hour while the families receiving public assistance used about 5 per hour. This was contrasted with discouragements. The professional families used 5 per hour on average and the families receiving public assistance used 11. They allowed the families to have other people come in. Instead of a laboratory sample, they were trying to get something that was representative of the kind of talking that typically went on in the home. The families knew this. So they had to include how many adults were talking. While researchers were looking at the amount and type of talking to the child, the talking among adults was certainly a variable. The point is the cumulative deficit that can go on by the ages of 1, 2, and 3 in terms of how much language the children are hearing. There is a striking difference, and we want to try to intervene earlier to prevent that.

Children need to hear speech in order to learn to talk. It is critical, and there does seem to be a critical period for language learning. Unlike some other skills, the rule of thumb seems to be the earlier the better. We want to help those families to enrich the environments for the children who are not moving along.

There has been a vast body of research looking at predictors of language development. If we just use measures of language, we could be waiting until the child is 2 years old and still not talking before we identify him. The biggest problem in our field is that we rely on words. There is such a wide range of variation in terms of when children start talking and how fast they acquire words in that second year of life. We want to go beyond that.

There has been some fascinating research over the past couple of decades looking at other abilities that are predictive of the child's language at age 2. The strategy that we are using is to look at these predictors and try to measure them in children closer to or under 1 year of age to predict whether they are likely to have problems in learning to talk. The areas that are identified are different aspects of nonverbal communication: (a) the expression of emotion, (b) the sharing of affect, (c) the use of eye gaze, (d) the rate of communication and quality of that communication, (e) the quality of their gestures that come before 1 year of age and the range of conventional gestures that we would be expecting, and (f) the quality of sounds, which are big predictors of the richer repertoire of sounds a child has at 12 months of age. This, in turn, will lead to a richer repertoire of words at age 2 and so on. The comprehension of words and the use of words are also key indicators. If the child is using words at 12 months, they are going to have better words at age 2 than a child who is not.

It is also important to look at the use of objects, which is very intimately connected with language development because children talk about objects that they are using. A better understanding of how to use objects and how to play with objects is going to be connected with their ability to talk. These are the areas that we want to measure and most of the tools in our field do not assess these areas at all.

The other thing that we want to do is bring in recommended practices for assessing young children. This is the challenging part as we are focusing on children under age 2 and are trying

to get down under age 1. In assessing very young children, one of the things that is important is that one uses multiple sources of information. We do not want to rely on one source of information because children can be so variable. The context in which one is gathering information can highly influence the kind of information one obtains. Researchers want to know not only what the child cannot do, but also what he or she can do and find out about some of their strengths. We want to get an idea of what it is that the child needs to further develop. We need to know something about the child's capacity for developing. The family needs to be actively involved so that we can begin the evaluation process. That starts with building consensus with the family and then building the intervention program with the family at the nucleus.

Researchers at the University of North Carolina-Chapel Hill suggested that the participation of families should be maximized and, if they can, the should take an active role in the assessment process. This changes the traditional thinking about the family in the role of the receiver of information, which is a passive role. There are many other roles that families can take in the evaluation and assessment process. They can certainly observe what is going on. We want to encourage families to be informants, describe the behaviors of their children, and help us to interpret the meanings of their child's actions and ways of communicating. We would like to ask such questions as "What was your child trying to communicate in that situation?" Or "Is this typical of your child?" We need parents to help us validate this information and determine its accuracy. They could actually be active participants in the process. Finally, the parent can make decisions about evaluation.

I would like to acknowledge a collaboration with Barry Prizant. We have developed two assessment tools. One is the Communicative and Symbolic Behavior Scales (CSBS), which was published in 1993. The CSBS was designed for assessment for intervention planning. It is a more in-depth assessment which one would want to do on a child when one already knows that there is something wrong and wants more specific information about the child's communicative abilities.

I would like to talk about the screening version of the CSBS. It is the quicker version to use when one wants to find more children. It includes all the principles of family-centered practice, with more efficiency, in 15 minutes or less. That is really difficult to do with an infant. We have come up with a three-tier system so that each one takes a little bit more time. The first tier is an infant-toddler checklist that parents fill out. The checklist has questions for which families can provide information easily because we are confident that parents can be good reporters of this type of information. They know their children and they are in a position to tell us what their child can and cannot do. This is a preliminary checklist that can be given out through child care centers, pediatrician offices, or anywhere that one may encounter children. It is not like a universal screening that one would necessarily give to all children, but it could be given out selectively where a practitioner may have concerns or parents raise concerns.

I would venture to say that in any situation where a child is disadvantaged, one would want to try to get the parent involved. Very often parents raise concerns to pediatricians or to teachers at the child care center. They may say, "I am worried. My child is not talking enough. Should we do something?" It is designed for that.

We have received funding to screen 1000 children in our community and that is about one fourth of the birth rate. This instrument is also undergoing national field testing right now so we will have national norms and interesting local norms. So far, we have screened about 350 children. The first step is a checklist that parents fill out. We have contacted all the agencies in our community to give this out. We have also given it out through a number of the HMOs—their groups of pediatricians—and any child care center that is willing to distribute it. For the parents who have lower education levels, most of them are hooked up with family service providers in our community who have been excited about this. They actually sit down with the family and go over it with them. It is probably going to require that type of assistance for much of the Head Start population. Then we follow up with a caregiver questionnaire, which is more

in depth. It provides more detailed information, but covers the same domain. Then, in addition, we have developed a systematic way to sample behaviors. This is a much briefer behavior sample and it is derived from our other instrument that gets a more in-depth sample. This is a quick sample although I cannot say that we have quite gotten it down to 15 minutes. With infants one just cannot do it that quickly. So we have gotten it down to 30 minutes, although one might be able to do it in 20 with a very cooperative child.

Let me explain some of our preliminary findings and then I will summarize. We now have a sample of about 327 children. It took about 3 months to get the system going and now we are screening about 100 children per month. It is flowing and gaining momentum. To give some background, this is all taking place in Tallahassee in the panhandle of Florida, close to southern Georgia. The boy/girl ratio in the study was 50:50. We were pleased about that. In terms of racial composition, we have a large African American population in our community and we were very determined to make sure they were well represented. Out of a study population of 372, the racial composition is 43% African American and 50% White. As we approach 1000, we need to increase the number of White families that we are getting. However, I am very pleased that we have been successful in terms of representing the African American community. The Hispanic population is relatively small in our community so we are slightly oversampled there. We also have a number of Asian families and families from other races. In terms of education level, about 8% have had some high school, 28% have high school diplomas, 26% have college degrees, and 39% have beyond a 4-year college degree. Our community is a little above average economically. The median income is higher than that of the national population.

Looking at the checklist, we began the validation process and asked whether it was in good agreement with the other pieces of the instrument. We have given the checklist to 327 families. We have also given the caregiver questionnaire to 190 of the 327. There is good interrater reliability (.89). It is reassuring that our quick version is in good agreement with our more in-depth version. We have collected behavior samples on 64 children and are following them longitudinally. We have very good agreement between the checklist and the behavior sample (.77) and the more in-depth caregiver questionnaire and the behavior sample (.76).

We are pleased with these findings. We feel like we have reliable, stable instruments. This gets at aspects of validity. However, we need to demonstrate sensitivity and we are not yet there. The tricky part of working with children under age 2 is deciding that there is something wrong. Right now, we miss most of the mild cases. It is much harder because there are no good instruments to establish concurrent validity.

We have done some follow-up studies. We took a group of 44 children starting when they were 12 months of age. They are just turning 2 now and so we are getting McCarthy scale scores on them at this age. I do not have enough of those yet to look at correlations, but will soon. We just looked at the test-retest in terms of our measures. We found that between the initial checklist at 12 months and their use of words on the caregiver questionnaire at 20 months, such as how many words the parents report, we have rather good interrater correlations between the sounds that the parents reported in the checklist, the words and objects at 12 months. They are all highly significant at .0001. Then we also looked at the words on the behavior sample. How many words did we get in our sample of the children? We found them to be highly correlated with sounds, words, and objects that parents were reporting at 12 months.

There are some good preliminary test-retest reliability data. Where are we going with this? Our biggest focus is early identification. At this point in time, our field is focused on children who have more medical complications. We tend to spend a lot of time following up infants who are premature, children who are exposed to drugs in utero, and children who have medical complications that are showing up early on in the hospital. Those children are followed, but the children who do not have the obvious medical complications are falling through the cracks. They are the majority of the children who end up needing special education. That is a lot of the Head Start population who may have developmental delays, but not obvious medical

conditions. So we want to validate the tool and we hope that by the end of 1998, we will have the national norms. Then we will be doing validation studies over the next few years. We hope that the Head Start population is the one that will be used. We also find the tool to be sensitive to measure growth over time. With children under 2, our goal is not to make diagnoses but to see whether this child is falling behind right now. Then we would watch them over time to see if we can help them catch up.

One of our goals is to set up a website. It will be up and running by the end of August, 1998. Our project is called the First Words Project. The checklist is in the public domain. It is now on the website of our publisher. It will be on our website as well so it can be downloaded and copied. We will then be giving information about cut-offs and how to make decisions. We are developing a lot of supportive information for families, pediatricians, and practitioners that we will also put on the website.

We are developing intervention programs that are really a menu of services for families with children that we have identified in our community as falling behind. Many are families very similar to Head Start families. We are pushing the notion of preventive family education support services. Whatever materials we develop, we will try to put on our website so that anyone—parent education groups, support groups, parent-peer playgroups—can use them. We also are developing intensive individualized interventions for those children who are significantly behind whose families expressed concern and want more help.

Gordon Williamson: I am from the John F. Kennedy Center in New Jersey. I would like to share some of the work that I have done on the adaptation and resilience of young children. As the director of an early intervention and preschool program, a number of years ago I became rather disconcerted. I found that there were a number of children who were making developmental gains. It could be documented on standardized testing, yet, when one talked to the parents and observed the children, often it seemed to make very little difference in terms of their functional living. In other words, the children were still having difficulty coping and managing every day living despite some of the developmental gains that had been made. So I started to think about what the coping styles of children are. What is the coping process in which children are involved in every day living? Particularly, what about children's coping with peers and their social competence?

I will be relating each of these broad areas with some of the research I have done. When I talk about coping, I think of it as the process of making adaptations in order to meet personal needs and to respond to the demands of the environment. Not everything one does is coping. Coping is in the middle of a continuum of adaptation. If something is so habitual, routine, and well learned, then that is not coping. That is at one end of the continuum. If it is something that is just neurologically reflexive, then it is not coping either, such as just pulling back when one has burnt one's finger. Coping is in the middle. It implies effort. It is what one does when one interprets a situation as threat, harm, or challenge to one's sense of well-being.

Many of us tend to think of coping as negative. When I am stressed out, I do not have the resources for managing and, indeed, that is a legitimate aspect of coping. Remember, though, that coping is inherent in any situation in which there is challenge. There is intrinsic motivation, curiosity, and a sense of discovery. So in that sense, coping has a very positive connotation. It is inherent in almost all learning tasks of children. The other important issue is how one copes with self as well as the physical and social world. One copes with one's thoughts, feelings, emotions, and changes in physical growth.

One of the interesting things on which I have focused recently is thinking much more about coping with self and not just coping with the external world. I think of developmental skills as the building blocks for growth. Coping or adaptive behavior is a synthesis and application of those skills in everyday living. Shirley Zeitlin and I over the last number of years have developed two inventories to look at one aspect of coping, which is one's coping style. The coping style to

us is one's characteristic way of behaving. Think of a swimming pool. One person sees a swimming pool and dives right in. This person is a risk taker. Another person comes up to the edge of the pool, looks at it, checks the water, checks the depth, and then plunges in. Another goes in inch by inch backwards down the ladder. So the issue is that there is a stylistic difference here. All were successful. They all got into the pool, but they did it in their own characteristic way. In part, that is coping style. The Early Coping Inventory that we have is for infants and toddlers. The Coping Inventory is for children 3 to 16 years of age.

I would like to highlight some of the items so that you get a sense of what we are looking at in terms of what makes up the coping style of very young children. In this case, these items are on the Early Coping Inventory for infants and toddlers.

The first major category has to do with sensory motor organization. Are infants upright, prone, on their side, or transitioning between positions? Some children have a high tolerance for certain positions or for moving between them. That can be a strength or a vulnerability. Another important one under the sensory motor organization category is the ability to demonstrate pleasure in body movement. When one sees a child who is flat, who does not seem to care at 6 months, who wants to suck her toes, that is a sign of marked vulnerability for her active engagement with her world. Another important aspect of sensory motor organization is being able to maintain visual attention. When young children are in a visually polluted environment, they often have a disorienting response.

Another major category we look at is reactivity, that is, those behaviors that are very much dependent upon environmental cues. Examples would be accepting warmth and support from familiar people, the capacity to react to the feelings and moods of others, or the capacity to engage in reciprocal social interaction. Imitation is an important aspect of social reciprocity. Another important reactive coping behavior is the ability to adapt to change, which was one of the great vulnerabilities of many children with whom we work. In some cases, the change may be positive. For example, in a group of children, I introduced a novel toy. All of them had an origin response but the actual coping strategies they used were based on their developmental capabilities. The smallest child just reached with her eyes.

I also had the opportunity to observe adapting to change in terms of a negative change. While two children started crying and getting fussy, the one in the middle had no affect at all because she does not have object permanence. It was out of sight, out of mind. She did not know what it was about anyway. Another important coping pattern in the reactive area is bouncing back after stressful situations. It is a lifespan strategy. Naturally, this is nothing more than coming home after work, after a hard day and having three Margaritas and a bag of Doritos.

The last area in the Early Coping Inventory looks at self-initiation. Examples of that would be initiating an action to communicate a need and the ability to apply previously learned behaviors. Independent problem solving is another example of self-initiation. For one child, I was mean spirited enough to put a very attractive sounding bell inside of her milk bottle. She was desperate to find out what was inside. She pulled it. She turned it. She flicked it. All these are coping efforts. She bit it. Then, perhaps, she thought, "What the hell, let mama do it." I think that toddler has effectively coped in this situation.

When we move into the older age group of 3 to 16, the Coping Inventory is much more differentiated, reflecting the coping patterns of this age. One can talk about coping with self as well as coping with the environment. Three dimensions are addressed. One has to do with productivity, particularly productivity in terms of whether one has behaviors that allow one to influence what is happening and have some personal control. That tends to enhance social engagement and self-esteem. Another dimension is flexibility. Many children are rigid and locked into their behaviors, as opposed to flexible, that is, having a variety of strategies and being able to shift between them or reformulating their goals if necessary.

Last, there is the active-passive dimension. It is a four-step model that helps me focus for assessment and intervention. Basically what one has when one is coping is an attention-

generating event, some kind of stressor or demand. The event is interpreted as a threat, harm, or challenge and then one decides what to do about it. One pulls on one's actual resources. The resources that we think are most critical are one's emerging beliefs and values, one's physical and affective state, one's development skills, and one's coping style. The external resources are material and environmental resources as well as human support. These four are the foundation for the intervention. One could do the assessment and intervention focusing on any one or more of those resources. For example, one could conduct an assessment in terms of the demands and expectations placed on the child and the nature of the stressors. One could assess and intervene in terms of the internal and external coping resources. One could actually assess and then teach specific coping strategies.

The child can use the contingent feedback that he or she receives. The idea for intervention is that one is trying to get a good fit between the demands and expectations from the child and the resources for managing them. These are the major options that one has for doing it. It is modifying the demands, enhancing resources, and providing contingent feedback. This is the frame of reference that we have used to look at coping style and assessment intervention based on the coping process.

We have been working on this for about 15 years as a model of intervention and early intervention preschool programming. One of our most recent studies followed 21 families with children under 3 years of age for 18 months. They were in the early intervention program. All of them had children who were developmentally delayed. We saw a positive shift in their coping rating scores after intervention. The children clearly were coping more effectively. What was more interesting was looking at individual children. For example, there was one child who made significant improvements. I find this much more important as a director since in program management we are looking at which specific coping patterns are the most resilient or the most accessible to intervention. In addition, we need to know what kinds of intervention strategies that we use seem most efficacious.

One of the things I became interested in is what the characteristic coping patterns are for children who have disabilities or children who are living in poverty. We did a study in which we had over 1,000 developmentally delayed infants and toddlers in early intervention programs. We compared them with 400 normally developing infants and toddlers. Two hundred were living in urban or rural poverty and were in Head Start programs. Another 200 were from more affluent backgrounds.

Here are some brief highlights of our findings. One finding was that there was a clear significant difference between the coping effectiveness of disabled children and those who were nondisabled, both in terms of their overall adaptive behavior as well as their performance in sensory motor organization, reactivity, and self-initiation. The disabled children were less successful. Another finding was that the greatest vulnerability was in self-initiation. Does that surprise you? Yet, when one looks at the nature of the programming that we do, one can see that we tend to focus on reactive behavior patterns, not self-initiation.

Another finding was that there were effective and ineffective copers in all five categories of coping effectiveness. Just because one has a disability does not mean one is going to be an ineffective coper. It just means that children with disabilities have more stress and fewer resources as a group. However, we all know children who are normally developing but very ineffective copers. Particularly I think of many of the gifted children who fall apart in the social domain.

The other major finding was that when we looked at that same group of 200 children who were living in poverty, their coping was less effective than those that were from more affluent backgrounds with family incomes over $10,000. To me, this is a powerful finding. It says that many of these children living in urban poverty may develop developmental problems later. The point is that they are significantly less effective in their management of every day living and their overall coping adaptation than children who are from more affluent backgrounds. Yet this is

before they may be showing any developmental difficulties. That is, there may be functional differences in daily management and living of some of these children before we see any identification of delays. What I have talked about up to now is the coping styles of children, basing intervention on the coping process.

What I would like to do is quickly look at social competence. I became interested in the fact that many of these children were falling down in the social arena, particularly with peers. So I developed an intervention approach that is activity based and play based. The typical approach for teaching social skills is an instructional one in which one models and demonstrates and then the children practice the different social skills of sharing, turn-taking, being able to introduce oneself into a group, and so forth.

Another approach focuses on cognitive problem solving—how to think through tasks. If we created a more naturalistic approach that focused on children engaged in group play activities, then we could intervene within the structure of the activities. In this way, we could help children expand their social skills.

Over about a 2-year period, we ran a series of groups for preschool, early elementary, and late elementary school children (n=120). Thirty-seven percent were preschoolers. I would like to share the findings from this group of children.

We looked at how egocentric the children were. We also looked at what the purposes were for their interaction, such as whether they were used for instrumental purposes or social emotional purposes. Also included were components of social competence, such as social and play behavior, prosocial skills, self-regulation, communication, and social problem solving. A problem in any of those areas can undercut social effectiveness. We found there was a decrease that was rated by clinicians. The intervention was for 3 months. We ran social skills groups during the fall, spring, and summer, and often after school. Now they are integrated into school and Head Start settings.

The after-school program was an activity-based play intervention. When we looked at these children using the Social Skills Rating System of Gresham and Elliot, we found that overall, according to the clinicians, there was a decrease in problem behaviors and an increase in social skills.

There also is a parent form. Parents concurred that there was a decrease in problem behaviors and an increase in social skills. Their numbers, however, were different. The parents, in general, felt the children were more impaired in the social arena than the practitioners. The reason is because they see the children in many more contexts. Secondly, they thought that there was significant improvement as a result of the intervention but not as much as the clinicians.

We were particularly interested in which intervention goals and objectives made the best gains. The areas that tended to show the most improvement were: following rules, use of body language and personal space, self-regulation, sharing experiences, regulating emotional states, taking turns talking, and regulating tone of voice.

Isaura Barrera: I would like to introduce myself first and foremost as a mindful practitioner rather than as a researcher. When Dr. Shonkoff talked about the research culture at the luncheon session, it affirmed for me both by my own native culture and personality that the research culture is a difficult one in which to operate. I do, however, find that I am a great asker of questions and I am a great synthesizer. I ask questions such as how does this piece that no one has talked about fit with this piece that other people have talked about and then bring those together. Part of what I am going to share is thoughts about how to change how we think about culture.

I have gradually and in a fairly circular fashion come to believe that if we are ever going to truly understand cultural diversity and if we are ever going to truly recognize and take into account both individual realities and social realities, then we are going to need to change how we are conceptualizing culture in relationship to assessment and intervention. Culture in this

context tends to be fairly compartmentalized. I always feel slightly schizoid when I submit papers to different organizations, some of which have tracks. I am asked whether this is in the cultural diversity track or in the assessment track. Most fall in both, but we can only check one.

What difference, if any, would it make in the data, bringing that variable in, not in terms of ethnicity but in terms of cultural dynamics? I am using Amy Wetherby's reported data as an example—not her own project but the data she reported about number of utterances. There are cultures in this world where the children do not have a great number of utterances per hour and the children grow up to be perfectly functional, intelligent adults. That does not mean that the children in this study were necessarily okay. However, it does ask us to integrate our lenses instead of looking through this lens or that lens, and develop what I call grasshopper eyes.

Through that integration we have multiple lenses for looking at things. When I started to reconceptualize culture, I realized that I had hung on to the traditional definition of culture for a long time. I am slowly beginning not to change it but unpack it in some ways. What we have traditionally focused on in assessment intervention is only the top layer. We have looked at behavioral expressions and social roles and rules. What we have not been good at is understanding the other levels of culture. What I believe culture is and where it starts is with shared experiences across families and across generations. The significance of that is that the families with whom we work do not have the shared experiences across families and across the generations that are presumed when we talk about the typical cultural package called, for example, Hispanic or African American.

In the US, we do not have clean cultural packages. We have ethnicity. That is fine, but that is not the whole of culture. Typically, as a result of those experiences across families and across generations, particular world views begin to crystallize. The best way to do something is X, or the world is really not a friendly place and one has to develop rituals to deal with that. Those begin to be crystallized and give birth to specific ways for sense of self, not only, for example, one's personal sense of self but also one's idea of what self is.

Is self an individual separate from others? Is there such a thing as an individual or are we talking more about cohesive units where the individual boundaries are quite different? Those same worldviews influence the funds of knowledge that a particular community will believe are important. Part of the reason that we have different data on language, on any kind of situation like that, is that the funds of knowledge of a community are quite different.

I grew up in South Texas. The funds of knowledge in my particular cultural community did not say that one had to be highly verbal. In fact, if one were highly verbal, one was considered disrespectful, not a very deep thinker, superficial, or filled with hot air. However, social interaction was given a great deal of value. There were 3-year-olds who knew how to greet guests and how to serve tea or coffee, but were not talking very much. It is difficult to decide at what point these variations are differences that lead to the outcomes that we want and at what point they become differences that might inhibit those outcomes.

The last piece is perceptions of power. This introduces a confounding variable of minority status into how we conceptualize culture. In almost all of the research that I have read, the distinction between culture and minority status is not addressed. Much of the data have their roots in ethnicity and in worldviews that have been influenced by minority status and by an imposed external, either implicit or explicit, sense of powerlessness. It is at that point, then, that out of those funds of knowledge and perceptions of power, the specific behavioral expressions that are what we can see come to the fore. I am doing some pilot research on the thoughts I am sharing, but it is difficult to begin to do research in this area because the research model and the research culture in this country are basically discreet and linear, even when they are qualitative. It is very difficult to look more at processes rather than products and events. I hope that I will stimulate some research questions today.

It is at these deeper levels, too, that synthesis occurs. When we are looking at sense of self, funds of knowledge, and perceptions of power, culture becomes inseparable from mental health,

from developmentally appropriate practice, and from brain research. The patterns of nurturing that particular families use are embedded in their culture. Part of the dynamic that happens with cultural laws and cultural disruption, cultural transition, or cultural shaming is that these embedded patterns can be lost, can be disrupted, and then not occur as they might occur.

So, in keeping with the language analogy, the top piece is the vocabulary. It is the syntax. Then it is the actual language that we speak. At the very bottom, we are talking about language and communication in general as an analogy. I believe that in order to do sound research in any area and with any population, we need to address some of the deeper levels of culture and not simply take groups that identify themselves ethnically and then attribute the results of the data to culture and culture's functioning in those groups. It is a nice way to categorize populations, but I do not know that it tells us much about culture as it is functioning in those groups. It is at that deeper level that culture's potential as a protective mechanism becomes evident.

Culture, when it is intact, when it has not been harmed or distorted by external events, is designed to act as a protective mechanism. It is designed to build into place the kinds of things that resiliency literature says that we need. I ran across this term "circles of beauty and walls of strength" in a book by Carol Flinders, called *At the Root of This Longing*. It is not about culture at all. It is a feminist book and it is talking about what it takes to deal with the violence done to women and children. When I read the term, however, I realized that, as I conceptualize culture, this is what I believe it to be. When it is intact, culture is the circles of beauty and the walls of strength that really allow us to cope. If we expanded Williamson's research on coping to the family level, then it would give us some analogies in terms of how and what we might need to do.

I am concerned that we have looked at culture and cultural diversity as a risk factor, rather than as a protective mechanism. That has a double-edge sword. Not only are we not accessing what needs to be there, we are also further disrupting and shaming the resources that at least potentially could create for families circles of beauty and walls of strength. In the research that I am currently designing—and this is an idea in search of a research format at this point—I selected those particular elements that the literature on risk and resiliency tells us are critical. I am looking at relations with adults, relations with peers, and hope, even though there is not as much literature on hope as I would like to see. I am also examining decision-making power, although I am not sure that power and competence will remain separate elements as I go into the research. The other element is identity. Risk and resiliency literature tells us that when these are in place and working well for the environment in which the family finds itself, one is likely to see positive coping and resiliency, and when they are not in place, one is likely to see a family who is at risk or is not able to cope at the level they need to.

We have some literature on the impact of cultural disruption and loss. What happens when culture gets shamed or lost, either through immigration, or through domination and oppression, as has happened with our native populations in the US, is that basic assumptions about how the world works are shattered. If one reads the literature on trauma, trauma is what happens when basic assumptions are shattered. So, when culture is not in place, there is a very literal way in which the circles of beauty and the walls of strength are not there. In actual trauma, coping styles and coping mechanisms are displaced and there is nothing to replace them with. There is not much information on this—it is mostly anecdotal data.

Stop and think what happens to a 3-year-old who comes from an environment in which the skills he has work for him. They may not, however, be the skills we want. They may not be the skills that he needs when he is going to be 12 or 18 in a different environment, but they work now. He comes into an environment in which these skills no longer work and sometimes he is ashamed because he does not feel competent. He may not be ashamed intentionally, but a child who has at the age of 3 begun to develop a sense of competence can suddenly begin to feel that the skills he has do not work and that he cannot make them work. I do not know how many of you have tried going from driving an automatic shift to a stick shift car or have tried learning a second language as adults. Most of the reason that we do not learn new skills as adults is

because of what happens when we suddenly have to face feeling incompetent in areas in which we previously knew ourselves to be competent. Without understanding this, we are asking 3- and 4-year-olds to undergo that same experience. If we do not reconceptualize how we think about culture, we will continue to do that and unfortunately and inadvertently in most cases, decrease children's access to the circles of beauty and walls of strength that they might otherwise have in place.

That does not mean that they cannot learn different skills or additional skills, but it does mean that we need to understand the value of their existing skills. There are anecdotal data that say that disruption, loss, or shaming of culture can have traumatic and disruptive effects. There are less data, however, about how culture supports and promotes these elements in ways that promote coping and resiliency.

Cross-cultural literature talks about how culture promotes a range of ways of developing this although it still does not look at risk and resiliency. That is where I think that our research needs to go. What we are doing at this point is reviewing case studies to look at how families who have children who have difficulties, behavioral, social, or medical, are able to cope or not cope and what role culture in the broad sense may or may not be playing.

I do not mean ethnicity. I mean culture. When families are faced with stressful situations in terms of childrearing, to what degree are their senses of self, their funds of knowledge, and perceptions of power coming into play? I conceive of culture as a social template or an organizer that helps the family organize around the behaviors that are necessary, at least in their worldview, to promote healthy development. It is analogous to psychological self-organization. My hypothesis is that when families have a strong, coherent culture to draw on, whether ethnic or religious or simply a culture that has no name, when they have a strong sense of who they are, when they have a strong and clear sense of the funds of knowledge that they need, and when they feel powerful and competent, that family will be better able to support the behaviors and the development in children that we are asking them to support. When that is not in place, then they do not have that same capacity for support.

Some of that research has already been done, but the filter of culture has not been used. We have talked about families being well organized or not well organized, but culture has not been put into that equation. My current research asks several questions. I have been very pleased as I have gone to different symposia and poster sessions at this conference and have seen reflections of these. I hope to leave you with these questions, so that as you conduct research, you think about these questions.

If any of you are interested in the questions specifically, I would be interested in talking with you, because as I said, we are in the stage of conceptualizing research designs. We have the idea and the concepts, but not the designs. Some questions are: (a) How can we assess not just cultural content, but also cultural process? (b) How can we assess the role of cultural dynamics in supporting and promoting healthy social emotional development, in other words, mental health? and (c) When we assess children's behavior, what are the effects of cultural loss or cultural presence and how can we assess those?

When a child is not speaking, for instance, or is not coping in ways that we would anticipate would be helpful and necessary, how can we assess the degree to which the culture dynamic might be helping through its presence or hindering through its absence or lack of organization? What are the circles of beauty and walls of strength that are available to this family with which we are working? Most families, if they have survived in the conditions in which I cannot believe I would survive, have circles of beauty and walls of strength on which they are drawing. How can we identify and assess what those are, so that we can get them in partnership with ourselves and work for the benefit of the child? When these circles of beauty and walls of strength are not in place, how can we support families to access them or create them?

There are studies that talk about families going back and relearning or readopting traditional cultures. That certainly is one way to do that. I do not believe it is the only way to do that, but I

think this kind of research requires that we look at culture in a different way and that we also look at interactions with families at a somewhat deeper level than we have been used to.

AUDIENCE COMMENTS AND QUESTIONS

Comment: I wanted to reemphasize some of the things that the last speaker was discussing. I think it is important to try to more clearly delineate culture and issues surrounding culture, ethnicity, and race. From my perspective, I see race as biologic. I see ethnicity and culture as some thing very different. I see race as a passive state. I see culture and ethnicity as more active or proactive. I think that in a lot of the studies that we have done throughout the course of history, we have looked at passive states and implied active states. It is important to take that into consideration.

Isaura Barrera: I appreciate that comment. I had not thought of it in terms of active and passive, but that is true. We do move to a more active conceptualization of culture, because what is biological in ethnicity in some ways is also inherited. One does not get a choice. To what degree that is then adopted and actualized is important. It is also important that we not restrict ourselves just to ethnicity.

There are a great many of you who, if I asked you what your culture was, would have a difficult time identifying it cleanly. Yet, we all have a sense of self, funds of knowledge, and perceptions of power. We all have specific worldviews and values and beliefs that support those views. It is important to take those into account, as well, because the families with whom we work do not necessarily have the clean packages that the literature describes.

Question: I would like to ask a question of Isaura. Would you make some comments about the relationship of culture, race, and ethnicity to assessment more directly than can be derived from what you have said?

Barrera: There are a couple of different pieces. When I think of the assessment process specifically, I think that one of the things that comes out of looking at culture through the model that I presented is that one needs to be able to identify one's own lenses. That is not only being aware that a grandfather came from Germany and a grandmother came from Mexico and so on, but looking at how self is defined.

What happens when one is assessing a child who is not autonomous in the sense in which one would define it? We need to be aware of the filters that we use when we assess and be aware that they are built into the instruments. That does not mean that the instruments do not provide useful data. If we are looking at utterances per hour, for instance, what filter is used? At least own the filter, the way that you are looking at it, and the belief that it underlies your work. That will clean up some of the data.

I believe assessment is about relationship and that one cannot assess someone with whom one is not in a relationship. One can get data, but a true assessment requires entering into a relationship and that requires that one honors and respects his or her reality. That is often difficult to do in the situations in which we work. Just because some of us may have clearer ideas of our cultural identity than others does not mean that by virtue of that we are necessarily more culturally competent, to use the term that is being thrown around.

What happens when, as I know in one case, one shows up to assess a 3-year-old and the mother has snakes freely roaming in the house, as well as the rats that feed those snakes? One is supposed to work on the floor in a naturalistic environment as one is doing the home intervention. There are some very concrete issues that come out of that, but I do not think that we necessarily have to know all the answers so much as we need to be respectful of different worldviews and somehow, at a very deep level, understand that millions of children grow up, as I said earlier, to be fully functioning adults in ways that are very diverse.

One might say they grow up in different cultures and often end up living in the US culture as adults and they manage just fine. Understanding that when we assess, we have indicators and markers, and those are reflective of specific worldviews and specific values, they should be taken as indicative of what they are. Again, I will make an analogy to language. If I am assessing someone and she does not speak English, I can assess her in English if my results then are interpreted as saying this is the level of English that she knows, if the results then are not generalized to say she has no communication and she is mentally retarded. The same thing for culture. We can assess them on the indicators that we have. It is the interpretation, the meaning that we then derive from the data that I think becomes critical.

Samuel Meisels: I would like to extend that last point that Isaura made and link some of the panel presentations in that it seems to me that we have learned a lot about alternative developmental pathways and the developmental disabilities field with respect to biological variation. We know practically nothing so far about alternative development pathways related to cultural variation. Underscoring what you said, I think it is incumbent upon us, especially in Head Start research, to identify the variations and strengths in cultural variation.

One has to do functional analyses as related to the development of different sensory motor systems and alternative developmental pathways and strengths that can emerge from using other sensory motor modalities than we might expect when there is a handicap or disability. By the same token, I think we know little about resources of strength that emerge in the variations of culture. That is one of the responsibilities and challenges we have in doing Head Start research.

Question: I have a question for Gordon Williamson. In terms of what you are doing with coping, do you see any potential in bringing in the cultural piece of that?

Gordon Williamson: I do not think one can talk about the coping effectiveness or coping activity without putting it within a context. Culture is a major aspect of that context. That became an issue in developing the Early Coping Inventory which goes from birth to 36 months of age. We had the whole issue of what kind of rating system to create. When we came up with a 5-point likert scale from minimally effective to situationally effective to effective more often than not, one of the things that we had to make clear in the use of that scale was that one is assessing the child regarding his or her developmental age, not chronological age. Additionally, in the context of his or her developmental age, one is looking at the cultural milieu in which he or she is functioning. If one decides where a child lies on a 5-point scale, one has to think about children's functioning in the context of everyday living and how they are managing their world. That is how we have tried to make sure that the inventory is culturally responsive.

Question: Did you find instances in which the parents would say that the child's coping was effective from their perspective but professional caregivers would disagree?

Williamson: Sometimes there were differences in perception of what was allowable as effective. Other times it was a real difference in behavior. The child is different at home than at the center. Sometimes it is a difference between parents' and clinicians' interpretations of a behavior. Sometimes parents will give credit to a child for an emerging developmental skill whereas a clinician may not. So there can be a discrepancy as to whether the child has the competency in a particular area or not.

Sometimes parents do not see or give credence to small changes in behavior to which a clinician gives great credence. While it may not have reached the level of a functional enough difference in coping for the parents to see, a clinician may see the change as a significant early milestone.

Comment: Speaking more from when the behavior was actually the same, I know of a family who was not ethnically identified. The child would strike out and fight and his father thought this was perfectly appropriate. The father saw his son's behavior as taking care of himself and standing up for himself and so would conceivably have rated that as appropriate for that context. However, I do not see that many Head Start teachers or early caregivers would have rated that as very effective. That is more the context I was thinking of.

Williamson: Exactly. That is interesting, especially the area of self-initiation, of what is self-initiative, and what is allowable and tolerated. The area that I find particularly interesting regarding the emergence of young children's competence is their emerging beliefs and values.

I do not think we spend enough time looking at children's unique ways of perceiving and valuing the world and their preferences and expectations for themselves and others and how these emerge very early in their development.

If one thinks about young infants, even such things as their expectation of success or failure and their degree of feelings of their own personal agency exist at an early age. They are emotionally based. They are clearly developing senses of self and that would be culturally related, I would think. Those ideas guide not only one's perception of the world, but also become a resource for protecting oneself that one can call on as a protection. For some people, though, it is vulnerability.

Question: Two people commented on the Hart and Risley data on language from two different perspectives. I wanted to get back to that in terms of thinking of Head Start staff having to work with families and being pressured to try to make a difference in child development, yet trying to be culturally sensitive. Are there any universals about good parenting that cut across cultures, so people do not use culture as an excuse to forgive behaviors that make a difference in children's growth?

Amy Wetherby: That is an excellent question. I am sure that all of you struggle with this as much as I do. This is a big issue in my community in the Deep South, in terms of community reference. What would be considered an acceptable discipline and what do we professionally feel is developmentally best-recommended appropriate practice? There are sometimes clashes there. I do not know that I have solutions, but I think that there are questions about how one may respect the family's culture, but also deal with clashes with what we consider developmentally best practices. I think discipline is one and use of language or quality of language input is another that we commonly face on a daily basis. I do not know that there are guidelines. There is a lot of discussion and there are many different milestones, norms, and data that one can find. I do not think there is agreement.

Barrera: We need to take it out of an either-or framework so that it is not either we respect the family's values or we teach these things that we feel are necessary. I think respecting someone's culture does not mean rigidly adhering to that and not adding any new behaviors. It would be perfectly appropriate to require, expect, and support different behaviors in the classroom or in the Head Start setting as long as it is done in an additive fashion, not a subtractive fashion, to use Jim Cummins' terminology. This means that one is not saying this is better so this other must replaced, but one is saying here is something that will enhance, enrich, and work in this setting, and what someone else does that works for him or her is fine and is respected. As long as it is not placed in a forced-choice format, we are safe. I am a strong proponent of children learning the skills that they need to live in the wider community, because the more options one has for behavior, the more power one has. Acculturation is perfectly valid when it is done respectfully.

Meisels: I also want to react to this with an example from what Isaura is saying. The performance assessment that I presented earlier is in use all over the country. It is in use in American Indian schools and in schools and programs in the South, the Northeast, West—actually all over the world. The way that it can be applied in so many places is that we ask teachers to learn to observe according to standards that, in fact, are set by a convention about the areas of development. That is one point of view or perspective. We ask them to then make an evaluation within the framework of the group of children with whom they are working, which can vary dramatically, even within the same community. We also ask them to look specifically at the child and the child's progress from one point to another point. Then we also ask them to get information from families.

We try to provide teachers with a way of integrating all of this information. One can get discrepancies, needless to say, across those different points of view. However, it is a reality that children do function differently depending on the perspective that is applied to their behavior. So we have tried to acknowledge that. That is one of the ways that the work can be used in a wide variety of cultural settings.

Closing Session

SPEAKER:
Edward Zigler
Sterling Professor of Psychology
Director, The Bush Center in Child Development and Social Policy
Yale University

Helen Taylor: Two years ago we gave Edward Zigler an award for his enduring efforts on behalf of Head Start. At the same time, Esther Kresh delivered a tribute to Ed. She had planned to say that tribute is as true today as it was 2 years ago and was going to repeat it for all of you today. She asked me to repeat that message and that tribute to him. I am so honored to be able to do that.

"I could introduce Dr. Edward Zigler by recounting the many accomplishments in his illustrious career. Instead, I would like to talk about some of his contributions that are even more special to us in the Head Start community. Today more than ever before we acknowledge the importance of fathers in children's lives, perhaps because we know that unfortunately in today's world so many children grow up without the guidance and love of a father. Head Start was fortunate. In the 33 years of its existence, it has always had fatherly love, guidance, and support through Dr. Edward Zigler. He was not only there from Head Start's conception, but he helped with the birth and was always there during the years it was growing up. As the good father he is, Ed was there to praise Head Start when it did well, protect, nourish, and encourage it during dangerous times, and admonish and correct it when he felt it could do better. But whatever the fatherly task, it was always undertaken with unwavering and unconditional love. Finally, after the child reached maturity, he was proud to assist with the birth of and to welcome the new generation, Early Head Start."

I want to repeat what it says on the plaque that Ed received at the last conference because I think it is still fitting today. It reads, "To Edward Zigler, Ph.D., the true father of Head Start. You have raised this child well." With those words of tribute, I introduce to you for closing remarks, Dr. Edward Zigler.

Edward Zigler: It has been a wonderful meeting, and a great number of people have contributed to it. I have watched this conference grow over its four iterations. There are three people in leadership roles that have made this happen. The three people are, of course, Esther Kresh who could not be with us today, and John Hagen and Faith Lamb-Parker. We sorely miss Esther's presence at this conference. These wonderful conferences, as you know, do not just happen. It takes a lot of work. So the dedication and hard work of these people merit our praise.

I am not going to try to summarize 4 days of very rich presentations. Even I do not have the guts to do that. I just want to share a few final thoughts that came out of the conference, all relevant to this conference, and all noted at this conference.

First, and Esther says it very well, is making two communities one. There has been some animosity between the practice and research communities in the past. These conferences have done a great deal to demonstrate not the conflict but the synergism that exists between practice and research.

Research and developmental thought play two important roles in the life of Head Start. The first is the theory that the basic work that we do that gives rise to the framework for what an effective program must be. The second aspect involving the research community is evaluation, research that should feed back and make the program ever better, the kinds of evaluations that will convince the people who pay for this program that the money is well spent. Good theory and good knowledge produces good effective programs. The wrong theory or erroneous thought produces poor programs. Unfortunately, Head Start was born in a period when our theory gave rise to essentially a program that did not really make a lot of sense from the viewpoint of what we know about children's development.

We can look back in time. I was there. We are back in the summer of 1965. We planned the program in 1964. The hope was to put 2,500 children into some kind of experimental program, since nobody knew what Head Start was. We wound up instead with 560,000 children that first summer, which was nervy of us. But what was the program? The original Head Start program in the summer of 1965 was either 6 or 8 weeks in length. Could you imagine promising that in 6 weeks we would take a child out of poverty and essentially make him wonderful forever? Do we have any theory that says that should be the case? I have been studying human development for well over four decades. It is difficult to change the growth trajectory of a child. In addition, what we heard this morning in two wonderful presentations is that poverty is worse. Things are not getting better. It is tougher. When we started this, we did not have the drug epidemic. We did not have the violence that we have today. However, we promised all this in 6 weeks. Where did it come from? It came from erroneous theorizing.

Two men who were both friends of mine and both very smart led us astray. One was Joe Hunt who, in the early sixties, wrote a book entitled, *The Intelligence of Experience*, which was the bible of the time. The other was Ben Bloom whose book was *Stability and Change of Human Characteristics*. Ben Bloom emphasized the importance of the early years, which is true enough. The work that we have heard at this conference says he was ahead of his time.

That period was a time of naive environmentalism. We overpromised because what we read in Joe Hunt was that very small changes in the environment of the child would have immense changes in the growth trajectory, particularly in the growth trajectory of the cognitive system. Once you started emphasizing the cognitive system, it was not surprising that when we started Head Start we were going to assess it by change in IQ, which Joe Hunt thought was very easy to do.

I had worked with the mentally retarded. It was not so easy to produce change. I knew how hard it was to change IQ. Furthermore, I thought the overemphasis on IQ was misplaced. There is a lot more to a child than his cognitive system. There are emotions, self-image, and motivation (which to me are equally as important as cognitive status). However, we got a little wiser with time. We grew. Our knowledge base grew. We learned from the practitioners. After the summer program, President Johnson and I had the privilege of standing in the Rose Garden when it was announced that Head Start would become a full-year program. (My own druthers would be for Head Start to be a 2-year program. Most of us in the middle class sent our children to nursery school for 2 years.)

It is imperative that we not overpromise what we can do with essentially a 1-year program. We must be honest. We must have realistic goals. The problems of children are much larger than what Head Start should be expected to tackle. We in Head Start are not going to change the figures that Professor Danziger gave us this morning. Poverty is destroying our children. Violence is destroying our children. The lack of any real day care system in America is destroying our children. Head Start cannot solve those problems. You could have the best program and the best curriculum, and that will not be enough to dramatically change the total growth trajectory of a child.

We must take Urie Bronfenbrenner's ecological model seriously. You have to change enough of the ecology, much of which goes beyond the family, to optimize the development of children. Telling the world that they should "give us children for 1 year and we will make them wonderful

until they are 35," is about like telling a mother if you are a terrific mother for 1 day in the life of your child, you do not have to mother anymore.

What we were stuck with in the sixties is what I refer to as an inoculation model. Joe Hunt convinced us, and we convinced the world, that we could take children in poverty and in a very short period of time inoculate them against all the ravages of the environment that they were going to see and experience over the next 20 years. That is not the model of human development that I have learned from my colleagues, from the literature, from empirical studies. What most of us believe is what I refer to as a developmental model. The child comes to us with his phenotype, be that as it may. He goes through a series of stages. At every stage of life, that child needs certain environmental nutrients.

We knew early on that waiting for poor children to become 3 or 4 years old was waiting too long. There are certain environmental nutrients needed in utero, for example good prenatal care. Therefore, you want to see that children from birth to age 3 get certain environmental nutrients and that parents get the support they need. After that, they go on to the next stage, which we call preschool. The nutrients received in the previous stage got them up there in an optimal way, but if you want to keep children moving forward, other environmental nutrients are needed. So children go from stage to stage, and it does not end when they hit school. If you really want to change the growth trajectory of a child, you need a long period of time with interfacing programs. We need Early Head Start, followed by a good preschool program, followed by good schools in which the child continues to get the right environmental nutrients and the family continues to get the support it needs, until the child is at least to about the third grade. Not that environmental nutrients are not needed after that. However, if you give me those first 8 years of life, that would give us the kind of robust effects that we are looking for.

I have to go to the Hill and testify, and I talk to the media all the time about Head Start. People keep asking the same question. They have asked it now for 33 years. Does Head Start work? You cannot answer that question unless you have a clear goal and an assessment of that goal. We have let other people tell us the goals of Head Start. It is the outside world that picked up what I consider to be the erroneous views of the inoculation model. So when gains fade out when the child hits school, that is Head Start's fault. Why is that Head Start's fault? Head Start cannot promise perfection in children. However, we cannot just say that we are going to do our own thing. Congress and the taxpayers have every right to ask us, "Does it work?" For the answer to that question we have to come up with our own goal. What then is a realistic goal for a 1-year program?

I believe the goal should be to improve the school readiness of poor children, which is not very far from where we started 33 years ago. We were getting children ready for school. Now, if that does not sound like a very demanding goal, you are wrong. It is a very demanding goal. In my paper *IQ Versus Social Competence in the Evaluation of Early Intervention Programs*, you will notice that the first aspect of social competence is that the child meets social expectancies. What is the most important social expectancy for a 5-year-old child? It is being ready for school. I have seen many path analyses about the later life performance of children. It turns out that school readiness is related to just about every other later school measure that we care about, whether the child winds up in special education or not, is in the right grade for their age or not, all the way to the point of dropping out of school or not. Furthermore, school reform is going on. We have the Educate America Act with its eight goals. President Clinton has pushed this very far. He did so when Bush was President and he was Governor of Arkansas. What is the first goal of the Educate America Act? Every child will show up at school ready to learn.

I wish we could all speak with a single voice. Sometimes we become our own worst enemies. We need to all agree and give the same message—we are in the business of preparing children for school. To do so, you must utilize all the special features of Head Start: teaching better parenting practices, encouraging parent involvement in the schools (which they first learn in Head Start), and teaching preschool skills to children. You have a construct—school readiness.

What is it? There has been a lot of debate that children should not be ready for school; schools should be ready for children. I know this debate. The fact is that if that is your goal, you are essentially saying children need certain types of skills.

What we must do is define school readiness with a set of measures that people can understand, and use those measures as our definition. If you do better on those measures, you are more school ready. Under Helen Taylor's direction, such an effort is going on as we meet. It is called the FACES study in which very fine investigators are developing a set of measures that will be used to determine whether Head Start is producing significant effects or not. They will use those measures as the ultimate outcome measures of the success of Head Start. This is a gigantic step forward for this program. I will continue to work with Helen on the effort, if she will have me. The fact is that the stakes are very high because if we cannot see improvement on those particular measures, then we will have failed.

I have read this literature now and have contributed to it from day one. I was a consultant for the Government Accounting Office Report which has hurt us very badly in this last reauthorization because in that report, they essentially said that we do not have clear evidence of whether Head Start works or not. I have reviewed this evidence many times, as have Steve Barnett and Bob McCall. I think the evidence is overwhelming that if you have a high-quality program, you will improve school readiness. I do not doubt it. We simply have to be careful that we have measures sensitive to the program that we have mounted.

I have been studying early intervention for a good long while, and I am convinced that there are two determinants to the effectiveness of intervention, no matter how it is measured. The same is true of day care. One is the quality of the program. The news is simple. Higher quality produces better outcomes.

The other is intensity. Arthur Reynolds has discovered, and most research indicates, that if you follow the preschool program with a later program in the school years, you get more robust effects down the road. The longer the program and the more intense that is, the more you stick with it and the more effective it will be. That is why I like a program that would last for several years, which is what they did with the Child and Parent Program in Chicago.

Helen was kind enough to share with me the Senate version of the reauthorization bill. Head Start has been like a "Perils of Pauline" existence for most of us. We go through periods when we are loved and periods when we are hated. This is not a good period for Head Start. I am not pleased with what is in the Senate bill. We still have not seen the House bill, and it may be even worse. They will have to go to conference. I am grateful to Helen Taylor, Joan Lombardi, Olivia Golden, Donna Shalala, and the President who have fought hard to keep the hurtful aspects of this bill to a minimum. However, the bills are still troublesome to me.

I will conclude with one final point. I have been a researcher and a practitioner because I once had the responsibility for this program nationwide. We have wonderful advocates here in the city. The National Head Start Association has played a tremendous role in advocating for Head Start. The Children's Defense Fund has done the same. However, I am going to conclude by saying it is not enough to be researchers. It is not enough to be practitioners. This is a political and social issue. All of us must also be advocates. We all have congressmen. We all have senators. We constantly have to do everything we can. We have to write op ed pieces. We have to write letters. We have to invite decision-makers to our Head Start Centers and make them advocates because that is what does it. To me, Head Start has been an affair of love. It has been a struggle. Whenever I see Head Start in danger, it troubles me. It is endangered now. I plan to work as hard as I can to keep the hurtful aspects in these bills to a minimum. I simply ask all of you to help in the struggle.

SYMPOSIA

Case Histories: Buttressing Reality With Research

CHAIR: Kay Mills
DISCUSSANTS: Edward Zigler, Saul Rosoff
PRESENTERS: Tim King, Kay Mills, Nancy Spears, Caroline Yellow Robe

Head Start directors presented descriptive case studies of their programs that: (a) reduce isolation encountered in a rural Indian agency, (b) provide social services to families, and (c) involve men in an inner city program. Also discussed was what studies could help improve their work and buttress policy makers' support for it.

Kay Mills: As a child of the sixties, I am a firm believer in hearing from people at the grassroots level—the ones who are encountering the day-to-day problems. I am a journalist by trade, not a researcher, academic, or practitioner. By listening to people who are doing the work, I hope to create a meaningful book about Head Start. With a bit of dialogue after the panelists speak, we hope to generate questions and suggestions about research in Head Start.

Over the last several years when writing my recently published book, *Something Better for My Children: The History and People of Head Start*, I traveled to many Head Start programs around the country, including the three represented on this panel. The book tries to tell the human side of Head Start: the people whose lives have been affected by the program, adults as well as children. I had the luxury of tracking one Head Start class that was about 55% Hispanic and 45% African American. I was able to see the changes as they occurred. Each of the panel members has a unique program.

Caroline Yellow Robe is a former Head Start parent. Head Start convinced her that her ideas were worth something, so she went back to school and earned her bachelor and master degrees. She ran the Head Start program at Fort Belknap, Montana, for about 19 years until she became a member of the first class of Head Start fellows working at the Head Start Bureau in Washington. She is now a consultant with Head Start.

Nancy Spears has been with Head Start since its beginning. She ran a Head Start program in Auburn, Alabama, in what she calls the "awful, wonderful first summer." Her programs included a Family Service Center and an Early Head Start. She currently directs a program that focuses on providing social services. She has also been instrumental, on several occasions, in lobbying to save Head Start and was a crucial member of the group that started the National Head Start Association.

Tim King was a student in Head Start during its first summer in Auburn, Alabama. He was a Head Start parent while he was in college. He is now Director of the Southeast Community Organization, the Head Start program in Baltimore. His program is working on getting men involved and addressing domestic violence issues.

Dr. Edward Zigler, a Sterling Professor of Psychology at Yale University, needs no introduction but I am going to give him a little one anyway. He has been extraordinarily helpful and supportive to me in completing my book and sorting through the research on Head Start. He was head of the Office of Child Development in the Nixon Administration, and his group developed the

first Program Performance Standards, the Home Start Program, and the Child Development Associate credential (CDA). He has been on every commission named to look at Head Start over the last few years, and, of course, he was on Head Start's Planning Committee in 1965.

Saul Rosoff was Dr. Zigler's deputy at the Office of Child Development in the early 1970s. He then took over as Director of the Office of Child Development in the mid-1970s when many crucial pieces of the Head Start program were cemented to create the Head Start that we know today. Later, he worked for the EPA and is currently a consultant.

Caroline Yellow Robe: I want to talk about Head Start and what it means to Indian people. I did not start in Head Start in an Indian program; I began as a parent in the Hill County Community Action Program. Because of that program, I became involved with Head Start and furthered my education after having been out of high school for 10 years. After I received my bachelor's degree, my goal was to become an elementary school teacher. My first job was on a reservation. I taught for 5 years at an all-day kindergarten with 26 children. I enjoyed it very much. The children in my class came from Head Start, which made me want to work in that program. I wanted to find out what was making them afraid of teachers and afraid of school.

I got a job as a Head Start director. One of my first tasks was to provide training for our staff. On the reservation Head Start opened doors for our people. It was not until Head Start arrived that Indian people realized that they could do other things besides staying home and being unemployed. The program helped them develop a career ladder, become advocates for their children, and design the programs they wanted for their children.

In other schools I attended, we never developed pride in our Indian culture or ways. In fact, we did not have our language because we were never permitted to speak the language. When my grandparents went to school, which was a Catholic mission school, they were not allowed to speak their language. Therefore, when we were growing up, they never taught us our language because they did not want us to go through what they went through.

The *Head Start Program Performance Standards* say that culture has to be included in the curriculum and it has to be relevant to the children and their families. Indians no longer had to have their cultural activities in the evenings or behind closed doors. In fact, many people did not know anything about their culture because they had never learned it in the public school or in a mission school. They had to go back and research their own culture, so it was not only a learning experience for the children but also for the parents and the teachers. Parents are a very important part of the program. Head Start taught our parents to be advocates for their children, not only on the local level, but also on a state and national level. At that time, there was a very vocal National Indian Parent Association. Perhaps they became too vocal, which is probably why it no longer exists.

This group was very important in getting legislation passed and changes started. When Head Start first began, it was thought that the teachers should all have education degrees. Some members of our tribal council said:

> No, a large number of the people on our reservations are unemployed. In the public schools, 99% of the children are Indian children, but there are no Indian teachers. By allowing our Head Start program to be a training ground for our Indian parents to become teachers and teacher aides, we will help them develop a career and help us to put more Indian teachers in the public school system.

This is what the tribal chairmen and the National Indian Parent Association advocated for. Otherwise they would have hired degreed teachers, and very few Indians had degrees at that time. Since the Head Start program came to the reservation, many Indian parents have gone back to school. In fact, in Hayes, Montana, where I was teaching, 100% of the elementary teachers were Indian. They all began as Head Start parents, teacher aides, and teachers, and they not only became involved in the school system but they also were elected to school boards.

Previously, 99% of the children were Indian and 100% of the school board members were non-Indian.

The research that would help Indian programs is research that is relevant to Indian people. I could read research about other minorities but I need something that is relevant to Indian people that I could use in developing our program, especially the things that were successful in other Indian programs. Another area that needs review is screening. Many of our Indian children are diagnosed with speech, language, and behavior problems. We would like to know if that is because the screening tools are not culturally relevant. That is a research question I would like to have answered.

Parenting is another area where we need more information. Many of our Indian parents were sent to Bureau of Indian Affairs boarding schools, so they did not have an opportunity to learn parenting skills from their own parents. They were institutionalized—they got up when the bell rang and they went to bed when bell rang. Everything was by the bell, and there were no parents there. Subsequently, when this group had children, they did not have any parenting skills. In Head Start, not only do we educate children, but also we educate parents and the community.

Nancy Spears: Our program began in that first "horrible summer" of 1965 as a part of the Alabama Council on Human Relations, a civil rights organization out of the Southern Regional Council founded by Dr. Martin Luther King, Jr. People wondered how in the world we got to a Head Start program. Actually, it was very easy if you look at what was happening in the South at that time. We were asked if the council would get involved in Head Start because the schools would not integrate at that point. The Council said yes, and the government sent us a huge amount of money to run the program in Huntsville and Auburn, Alabama.

I was involved with the Alabama Council on Human Relations, and since my background was in psychology with an emphasis on child development, they asked me to read about Head Start and its goals and say whether or not it was a good program. I read the materials one night and could not put them down, although there was not very much to read then. I told the board, "Oh yes, we want to do this, and let's do it right here in Auburn." Huntsville fell through but we did start the program in Auburn. We convinced our three school systems to allow us to use their buildings and their buses in the rural areas. One year earlier we had had the first integrated play program ever in the South in Tuskeegee. We had imported White children from Auburn to be in the Tuskeegee program in order for this to be brought about. The schools let us have the buildings, not knowing we were going to import White children from Auburn to integrate the program. We pulled it off that first wild, crazy summer. We did not think about what we were going to teach the children per se because we called it a play school.

After that summer was over, we realized suddenly that we could not do any more. So I put together what I called the Follow Through Program and asked Washington to let me use all the money that was still available for the Head Start families in the Social Service Program. Believe it or not, they said yes. We hired social workers to go into homes to help the parents of the children we had in the summer. After that winter was over, the Head Start parents that sat on our Parent Advisory Committee said to us, "Why can't we have this program all year?" In our wisdom, we went to the churches in the rural community and to Atlanta, and within 3 days we had churches willing to have the Head Start program. We then started a full-year Head Start program.

It was important to us to have the right curriculum. However, it was also important to us to have Head Start parents as the teachers. We instituted a 12-week training program even before we started the Head Start program. Because we were in a town with two universities, Auburn and Tuskeegee Institute, we were able to have a variety of people to come and help train the Head Start parents. Next came the food program. We thought this was supposed to be for programs like Head Start. We applied for it and were turned down. Our program, along with another program and the backbone of Marian Wright Edelman and her lawyers, sued the Federal

Government. We did get the food program. Now food programs are so prevalent in this country that most people do not even remember what an effort it was to get that entitlement. Next came the WIC Program. We had the WIC Program in the Health Department in our county but we felt that our parents were not being treated well. We decided we wanted to run our own WIC Program. On rereading the legislation, we discovered that we could run our own program, but we had to sue the state of Alabama because they would not give it to us. Eventually, we got the WIC Program.

We have continued with housing and the social service programs because we always had parents saying, "We need a decent place to live and food to feed our children." After one tries to meet basic needs, then one can sit down and talk to parents about the education of their children. When Head Start first began, my ex-husband said, "We really ought to have a small pilot program to research what is going to affect these families." Had we done that, we would have never had Head Start. Of course, we have done the research since and have found out that we have done some things very well. I wish we had done some research before welfare reform to see what families needed now and what they would need in the future, and how we could meet those needs with limited means, which makes our job much harder.

Tim King: I am going to tell you about my program and what we have been doing. One of the things that I will talk about is the uniqueness of the program because it is in an urban setting. Our program is located in southeast Baltimore. We began about 7 years ago, and now have six locations with very distinct populations. One has an American Indian population, another has a Latino American population, one an African American population, and another a European American population in the six sites. This diversity created challenges when trying to recruit the different populations and when trying to teach some cohesiveness with the different groups.

This year we began a program in the Baltimore American Indian Center. We wanted to bring in Head Start Program Performance Standards and the other services that Head Start provides to a child care center. However, we did not want to negatively impact the child care center as far as funding because they were a for-profit program. To get around this, we created wrap-around services. We shortened our Head Start day to 4 hours, so from 7:00 a.m. to 9:00 a.m. the child care center operates, and from 9 a.m. until 1 p.m. the Head Start program operates, and then from 1:00 p.m. to 5:00 p.m. the center operates again. I do not think this was a total win-win situation. The child care center had problems filling the classes, so we brought more children in. However, the parents won; they had extended hours. Of course, we won by providing services to all the needy children in the community. It was a wonderful match. We are still trying to fine-tune some problems, but it is a unique program and hopefully we can expand on this collaboration between child care and Head Start.

Another unique program combines Head Start with Spirit, an after-school violence prevention program that operates after the 3:00 p.m. to 5:00 p.m. Head Start program. Spirit operates from 6:00 p.m. to 12:00 a.m. We extended the age group to include ages 5 to 12 so that we also serve siblings and parents, and work with the entire family. In our community, there have been several children who have witnessed violence, some who have been victims of violence, and some who have even begun to exhibit violent behavior.

Barbara Curtis, my aide coordinator, brought the issue of doing research to my attention. She was doing research at Johns Hopkins University and asked if we could do research with our families. The families agreed to participate. A little girl in our program had a bullet wound in her arm. When she was cleaning the wound, she said, "This is a day that I died." We knew that we had to do something to address the issue of violence. On an even sadder note, yesterday at a Head Start program in Baltimore City, a Family Services Coordinator was murdered while dropping off her children and the children witnessed that.

These are some of the issues that we have to address every day. Unfortunately, our children are growing up in this environment. Head Start with Spirit is a demonstration project. We are

trying to create a program that can be duplicated not just in this one site, but in all our programs, and also nationally. The Spirit program is funded by the National Black Churches, and they have programs all across America. Hopefully what we learn and what we do in this program can be duplicated with other Head Start programs and churches.

Head Start with Spirit, tries to affect five different domains: families, schools, peers, community, and media. A number of research projects are looking at violence prevention and certainly we would like to tap into some of that research and collaborate. We would like to collaborate more with child care centers, for-profit and nonprofit. We would like to bring unlicensed child care providers into the loop and also make referrals.

The only way we can answer questions about providing services for children is to try to partner and collaborate with other child care providers. We need to be more aggressive in trying to collaborate with Child Find and some other programs in our community. Also, we need to work with the public schools and get them to open their doors in the afternoon to provide other services.

Edward Zigler: We have been treated to three wonderful presentations. First, referring to Kay Mills' introductory remarks, when one hears the word "research," we must remember that there are all kinds of research. In particular, the case study method, in which individual cases are examined instead of mean differences between groups, has not been done enough in Head Start and that is why Mills' book is so important. We simply do not do enough to capture these rich stories. I know the importance of these stories because whenever I testify before Congress, they will bring in a Head Start mother and she will tell her story. I have been at a dozen of these hearings, and believe it or not, it is the case study where a mother says what Head Start meant to her and what she got out of it that carries the day. That impresses Congress members and the media a heck of a lot more than academics like me. We should use case studies more often.

Caroline Yellow Robe's discussion also brought back some memories. I am proud to say that early in the life of Head Start we were aware that certain populations had special problems. There is poverty and then there is Indian poverty. In the visits I made to reservations around this country, one would think they were going to a third world country. It became obvious that these populations needed more help. For that reason we set up an Indian branch within the national office to make sure that Indians got the attention that they needed—and still need. That branch is still there and in good hands.

Kay Mills' remarks also made me think back to a book that was prevalent before we started Head Start, a book that was out in the early sixties entitled, *Cultural Deprivation*. The concept behind the book was that people who were poor were deprived of a culture. That is nonsensical on its face. There is no group that I know of that does not have a culture. The author was essentially saying that anyone living outside of standard, Caucasian, middle-class culture was culturally deprived. One of the great accomplishments of Head Start was that it ignored the concept of cultural deprivation, overcame it, and moved to a place of respect for all people's cultures. I think that was a good step.

An issue that has come up with a couple of our speakers is that there are still problems in Head Start. Head Start keeps changing, as it should. One of the great breakthroughs in Head Start was parental involvement. No program had the kind of parental involvement that Head Start had. However, there exists a gap between the intention and fate of those who advocate hiring local indigenous parents to run Head Start versus those who say these children need the very best that we have and ought to be hiring very high quality teachers. There has been suspiciousness on the part of Head Start towards professionals, and that has got to be resolved before another 33 years pass. There is a tension in Head Start between hiring local staff who represent the culture and defining itself as a program that is totally motivated toward children's optimal development.

We have been debating that issue for three decades, and we are going to have to continue to debate it. We might be able to achieve both goals if we are serious about creating career ladders.

If we do everything we can to see that the parents we take into the program do not stop after receiving the CDA but go on to earn bachelor's degrees and become fully qualified professionals. I agree with Caroline Yellow Robe that unless research is done on the particular population of interest, there is not very much knowledge. There should be more research done on Indian populations because this is a unique population. We should be doing research that will speak to their particular needs and characteristics, just as she suggests.

Her point on measurement is well taken. I have been a researcher my whole life. Most of the measures that we are using on Indian reservations and with Indian populations have never had Indians in the standardization group, so the measures are inappropriate. I am working with an Indian tribe in Connecticut. They happen to be a very wealthy tribe, and 90% of their children are labeled learning disabled. That is absolutely impossible, yet they are getting these labels that then steer them toward a path that is detrimental to their growth and development.

Nancy Spears is a Head Start heroine. I cannot praise her enough. We have made some progress since that first summer in the South, where we faced resistance due to the forces of segregation. I want to conclude with an idea that we have to keep working on. When we are totally satisfied with Head Start, we are through. I wrote a chapter in the first book I did on Head Start entitled, "Head Start: Not a Program but an Evolving Concept." We have to keep evolving and continue to improve our quality.

In terms of integration, our country is far from perfect, but we have made great progress since the days when people did not want Head Start because it meant integrating across racial lines. However, we have a continuing problem in Head Start. The Chief of Civil Rights of the former Department of Health, Education and Welfare (HEW) in 1970, Stanley Pottinger, was very concerned that Head Start was not very integrated. One can go to Head Start centers today and still see children who are all Black, White, yellow, or brown. We keep talking about the world of diversity that is coming. As most of you know, in about the year 2020, White people will be the minority and all the minority groups today, taken in total, will be the majority. So we have to get our children ready to live with diversity, and when I hear about the efforts that Nancy Spears made 33 years ago to integrate a program, I think we should continue those efforts. I, for one, am still not satisfied with the mix of children. I was able to talk Pottinger out of prosecuting Head Start at that time, but I do think that integration is important.

Saul Rosoff: First, I clearly endorse what Ed Zigler said. One of the things that struck me through my career was that the strength of Head Start lay in the Head Start centers, and that if the centers did not deliver a good program there would be no Head Start, no matter what we did in Washington. Time and again this proved to be so. We can advocate in Washington and try and put in new designs, but ultimately it is what happens with the children and what happens when people and the press visit the program that is the ultimate future of Head Start.

The research needs of the Indian people and the many other problems of disparity in terms of opportunity leaves an open field for us to make recommendations that efforts be undertaken. Helen Scheirbeck and Helen Taylor are clearly responsive to the needs of the program, and these issues need to be brought to their attention if they are not already aware of them. I believe they are aware of many of them and try to address them. We need to move forward on a special agenda.

Of course, there is Congress. When we think of how to influence them, part of the issue is that we need congressional relationships. We found when we testified that the members of Congress wanted to know what we were doing to improve the status of the children. At that time, both parties were supporters of Head Start, supporters of our concept, and supporters of what we were trying to do. Research is important and research can serve as a shield for the future. I would hope that members of Congress would still be sympathetic to that type of an approach, and at least we would have an opportunity to get the programs on the record. Again,

it is the centers that can implement services to address the various aspects of need that will help Head Start to continue in the forefront of children's programs in this country.

Question: I have a question for Caroline Yellow Robe. How should research be done on Indian reservations, and why is there so little?

Yellow Robe: I do not know why there is so little being done. Maybe it is because we are not close to a university or college campus. That is one of the major factors affecting whether research is done. I do not know how states are chosen for research projects. To address the question of how it should be done, there are 33 Indian community colleges in the US now. Getting them involved in the research would be a benefit to the Indian people that they are serving. In Montana, there are seven reservations and each reservation has a community college. The desire for research has to come from Indians, and they want research that they can use and that will be a benefit to them.

Mills: It does have to spring from the people. How to build a desire for research is another part of the question. How do you get people to want it?

Comment: The programs I dealt with were very receptive to research.

Mills: Do you suppose that part of that is because you did not try to go where you were not welcome? When traveling around to Head Start programs, there was only one place that did not want me. It might have proved to be one of the most fascinating because they were having a lot of upheaval on their Parent Policy Council. I would have loved to have seen that. However, you cannot go where they will not have you. That is another research problem: Some of the more interesting programs to study are the ones in some kind of trouble, and you cannot go there if they will not let you come.

Question: Tim, could you talk a little bit about male involvement projects?

King: A few years ago, I was a coordinator and was addressing male involvement. I found that many centers were not father-friendly. The term "fathers" does not necessarily describe who is involved with the children, so the term "significant male" is probably more appropriate.

Right now in welfare reform, I think that child support is a research issue. Men need to obtain the proper information about their rights and what they should be doing. Many men make contributions to families but it is not through the courts, and so they do not get credit. Men need to know the law, so that they will not run away from the courts. This will get some of those men more involved. Early intervention programs are also important. I have colleagues who are working with young fathers during the prenatal period—getting men more involved earlier, even before the children are here. Those are important issues. It is always a struggle.

It is necessary to be proactive in getting men involved, not only with the children but also in the issues that may prevent them from being involved. There are many stereotypes to knock down about being caregivers and nurturers, but men need to talk about these things. The females in the program need to know how to engage men, get them involved beyond traditionally masculine behaviors, and how to show them some of the nurturing aspects of fatherhood.

Comment: To add to that, there is another program in Baltimore where men are trained as bus drivers and aides so that the children see men in the centers during the day. The bus drivers not only drive the buses, but they come in and help bring the meals to the classroom and work outside and inside the classrooms for part of the day. There are a variety of programs that work.

Question: Why do mothers raise their sons differently?

King: Kwanza Konjufu wrote that mothers raise their daughters and love their sons. They teach their daughters how to survive—cook, clean, and take care of themselves whereas they just love their sons. Therefore we as sons are not as responsible with homework and other family issues. Certainly, there are many stereotypes there, however, we need to engage our sons more in nurturing. There are many traditions about little boys doing certain things that are not masculine, such men are not supposed to cry. Actually, it takes a strong person to cry and be able to show emotion.

Traditionally, mothers raise their sons a little bit differently than they do their daughters. One of the things that my wife and I try to do with my son is create a balance for him that includes nurturing, as I do with my daughters. Those are some of the issues we discuss in the men's group.

Comment: It is evident that there needs to be more research, which needs to get to the center level, such as how and what has been studied about how to raise young men to be more nurturing, and how to translate that into practice.

Question: Is there a relationship between the case study and the process approach?

Zigler: The case study can take one very far. Case studies can assist in generating hypotheses. To provide some background to the question, a child experiences a certain environment. That environment could be Head Start and all of the things that are happening around Head Start. How does that actually spell itself out? How do you get that environment inside the child to form a motivational system or a cognitive system? Why is a child better, smarter, or nicer because he or she was in Head Start? Those questions are left unanswered. There is a good deal of evidence that interventions work. We are beyond that. The question is why.

We need to get away from means and instead try to figure out what works for whom. There are hardly any studies of that kind. We get caught up with the mean of this group and the mean of the comparison group, and with making comparisons. Does anybody believe that a Head Start program does not have more effect on certain children than on other children? After the 33 years that Head Start has been around, we still do not know because we have what is called the problem of the match that affects a variety of children. We keep wanting to fit children to our program.

Now Head Start is a damn good program. We have polished it and done well. However, we ought to develop different programs for different groups of children. We have made no progress on that yet. One of Head Start's strongest points is that while programs must meet performance standards, the programs at the community level have a lot of leeway in picking the curriculum to meet the special needs of particular groups of children. That is one of Head Start's strengths, but it is not in the literature. That is why we need a better partnership between practice and research—because the real strength is not in Washington, it is with the Caroline Yellow Robes and the Nancy Spears of this world. They are doing interesting, fascinating things.

One of my criticisms of Head Start is we have not learned enough from the service providers. We have not done systematic searches of good ideas, new forms of Head Start, and what is happening at the local level that we should be sharing around the country.

Mills: Along the same lines, the case history method works when the results can be distributed so that other people can see what has been done. In the case of severely disturbed children, I found a program in Montgomery County, Maryland, that takes about 3 children out of 10 in a very small 10-child Head Start class. They mainstream the children but in a smaller, more manageable group with specially trained teachers. That puts more of a load on some of the

other parts of the program, but that approach can work in some places with a big enough program. Others around the country need to know about that.

At the Research Conference 2 years ago, I found two case histories. There was a report on the Asthma Education Project that the ABCD Head Start program runs in Boston in response to finding that approximately 14% of their children had asthma. They needed to train the teachers in what to do in case of an asthma attack and work with the parents and the children on preventing an asthma attack. I was able to incorporate that into a story for my book. The other case history was from the Texas Instruments Foundation that worked very closely with a Head Start program in Dallas on reading readiness. They stuck with the program when the results were not good after the first 2 years and designed a more intensive program. It is not enough to tell people how it was done; there must be a way to figure out ways to disseminate this information.

Question: What is behind the diagnosis of so many Indian children as having speech or behavioral problems, and is that true in other cultures?

Yellow Robe: There are several different instruments that are being used to evaluate the children and the issue is whether they are relevant to the Indian culture.

Spears: I was at a migrant Head Start program that I mentioned earlier, and many children there have delayed speech and stuttering or pronunciation problems. Often, it is because they hear Spanish at home. They watch television and they hear English and maybe see some Spanish television, but out in the world they hear English, and it is hard for them to process it. Additionally, the self-esteem needed to cope with language problems may not be there when children move around every 6 to 8 months. They are still suffering from what we suffered from in the South. When we first began our program, I remember one evening being called by one of my teachers who said, "Nancy, do you believe that my child is being put back in school?" It ended up that this child had an IQ that went off the charts, but because that child was African American, the child was being put in a retarded classroom in the school system.

Our program refused to have our children measured until the measures were tested on African American children. We just refused. We were lucky because we had Auburn University and were able to develop our measures and test them on children and make sure they were appropriate. Children are still suffering from use of inappropriate measures.

King: We have a high rate of children with learning disabilities in Baltimore City, and much of it is the testing mechanism. With IQ tests, those same cultural biases may exist. We face some of those same issues.

Question: How does Head Start take into account the fact that Indian parenting practices may be different?

Yellow Robe: There are two trainings that Head Start sent to our program: Exploring Teen Parenting and Looking at Life. From our parents' point of view, they were too long and did not include enough of our culture. The parents joined with some of the local trainers who had experience in developing parenting curriculum and they developed their own culturally relevant curriculum. On our reservation we have three tribes: Chippewa, Gros Ventre, and Assiniboine. Once the parents complete the program, they will often sign up to go through it again because they have said they got so much out of it the first time. One of our state congressmen, Pat Williams, came to our reservation to meet with the parents who went through the program and said he too would like to go through the program.

Question: How should we spread these good ideas around?

Zigler: We do not have enough mechanisms to disseminate information. These conferences that ACYF started under the leadership of Esther Kresh are so important for that reason. We are going to have a new mechanism that I will bring to your attention. The National Head Start Association is creating a new journal called "NHSA Dialog: A Research-to-Practice Journal for the Early Intervention Field" to better cross-fertilize between research, innovation, and practice. I think ACYF has to take much more leadership. There are interesting things happening, such as a partnership between Sharon Darling's Adult Literacy Center and Parents as Teachers. They are now on a number of reservations, and have adapted their programs. Indian mothers and fathers, just like African American and White mothers and fathers, want their children to succeed and there is a tension between protecting cultural values and making sure that the child at a fairly early age is inculturated in mainstream activities. For example, if a child has the characteristics of an Indian population, which values silence, and he goes to school and he never raised his hand to answer a question, that child is not going to be terribly successful. A very careful mix is required to protect culture and cultural values and build upon styles. I appreciate cultural variation, but we are all members of a common species. We forget the commonalities that we have as human beings. Humans are terribly adaptable creatures.

Mills: The research panel that I believe Sheldon White chaired for the National Research Council came out with a report about 2 years ago and one of its findings was the need for more information so that the wheel is not being reinvented.

The Comprehensive Child Development Program: A Longitudinal Study of Early Experience and Development in an At-Risk Population

CHAIR: Michael Lopez
DISCUSSANT: Sheila Smith
PRESENTERS: Robert G. St. Pierre, Barbara Goodson, Jean Layzer, Joan McLaughlin

The Comprehensive Child Development Program (CCDP) was an innovative attempt by the Administration on Children, Youth, and Families (ACYF) to ensure the delivery of early and comprehensive services with the aim of enhancing child development and supporting low-income families in attaining economic self-sufficiency. The CCDP grantees included universities, hospitals, public and private nonprofit organizations, and school districts. Twenty-one CCDP projects funded in fiscal year 1989 participated in an impact evaluation conducted by Abt Associates for ACYF. This symposium presents some of the findings from that evaluation. Four papers will be presented: (1) National Evaluation of the Comprehensive Child Development Program: Summary of Findings; (2) Individual Differences and Developmental Patterns in Cognitive Functioning for At-Risk Children Age 2 to 6 Years; (3) Stability and Change in the Parenting Skills of Mothers and Economic Development of Low-Income Families; and (4) Fathers and Father-Figures of Low-Income Preschool Children.

The findings from this 5-year, longitudinal evaluation of a major federal initiative for at-risk families are directly relevant to many different types of programmatic efforts including family support programs, two-generation programs, case management interventions, child development programs, and service integration programs.

■ National Evaluation of the Comprehensive Child Development Program: Summary of Findings

Robert St.Pierre, Jean Layzer, Barbara Goodson, Lawrence Bernstein

The Comprehensive Child Development Program (CCDP) was an innovative attempt by the Administration on Children, Youth, and Families (ACYF) to ensure the delivery of early and comprehensive services with the aim of enhancing child development and supporting low-income families in attaining economic self-sufficiency. The CCDP grantees included universities, hospitals, public and private nonprofit organizations, and school districts. Twenty-one CCDP projects funded in fiscal year 1989 participated in the impact evaluation conducted by Abt Associates Inc.

The impact evaluation was conducted in 21 CCDP sites. Grantees in urban areas were asked to recruit 360 eligible families at the start of the program (120 to participate in the program, 120 for a control group, and 120 for a replacement group), while grantees in rural areas were asked to recruit 180 families (60 for each of the three groups). Across the 21 projects, 4,410 families were included in the evaluation—2,213 families were assigned to CCDP and another 2,197 families were assigned to the control group.

Annual data collection was conducted over a 5-year period on more than 100 different outcome measures for each mother and focus child while lesser amounts of data were obtained from fathers, and on children born after the focus child. High response rates were obtained (data were collected from 89% of the families in the original sample at least once during the life of the evaluation) by well-trained data collection staff who lived in each of the 21 sites.

We compared outcomes for CCDP families with outcomes for control group families over a 5-year period and reached the following conclusions:

1. Five years after the program began, CCDP had no statistically significant impacts on the economic self-sufficiency of participating mothers, or on their parenting skills.
2. Five years after the program began, CCDP had no meaningful impacts on the cognitive or social-emotional development of participating children, nor did CCDP have any impacts on children's health or on birth outcomes for children born subsequent to the focus children.
3. CCDP had no important differential effects on subgroups of participants (e.g., teenage mothers vs. older mothers, mothers who entered CCDP with a high school diploma vs. mothers who entered without a high school diploma, mothers living with a partner vs. mothers living without a partner, male vs. female children).

These findings suggest that if the aim is to enhance child development, then it is important for Head Start to maintain its focus on center-based early education services for children. Research shows that children's development can be enhanced by a high-quality, center-based early childhood experience. Although case management, parenting education, home visits, and service integration are popular approaches, and we may want to provide these services because we believe that there are still some unmeasured benefits, there is no high-quality research showing that these alternatives lead to positive effects on children.

■ Individual Differences and Developmental Patterns in Cognitive and Social Functioning for At-Risk Children Age 2 - 6 Years

Barbara D. Goodson, Marc Moss, Anne Ricciuti

This paper presents findings from a longitudinal study of cognitive and social development of preschool children from families with very low incomes. The sample consists of 3,961 families who participated in the evaluation of the Comprehensive Child Development Program. All of the families had incomes below the poverty level and children identified as needing supportive services to enhance development. Repeated assessments were made on the child's 2nd, 3rd, 4th, and 5th birthdays. Most families (72%) were assessed four or more times; an additional 11% were assessed three times. Three standardized assessments of children's cognitive/language development were administered (the Bayley, the PPVT, and the Kaufman ABC) as well as three measures of social functioning (the Achenbach Child Behavior Checklist, the Adaptive Social Behavior Inventory, and a developmental checklist). Information was collected on parents' economic self-sufficiency, parenting attitudes and behavior, and health and well-being. Longitudinal growth curve analysis was used to estimate developmental trajectories and the strength of a set of time-invariant predictors (child characteristics, ethnicity) and time-varying predictors (family economic circumstances, maternal depression, maternal substance abuse, and family stress).

The children from low-income families scored significantly lower than a national standardization sample of children (a difference of about 1 standard deviation) on cognitive development, at ages 3, 4, 5, and 6. The difference between the CCDP children and the standardization sample appears to diminish slightly after age 5. The growth trajectory for the children from low-income families is curved: the growth rate from 3 to 4 years is slower (flatter) than the growth rate from 4 to 5 years.

Three time-invariant child characteristics were significantly related to development on the PPVT:

1. Gender: No effect on level or rate of growth.

2. Birth Order: First-born children score higher than do later-born children, but there is no difference in their rate of growth.
3. Birth weight: Low birth weight children start out at age 3 with significantly lower PPVT scores, drop a little further below at age 4, and then begin to catch up. The growth rate for the low birth weight children is faster after age 4 than it is for the normal birth weight children.
4. Ethnicity: At age 3, African American and Latino children are similar and White children are scoring, on average, 4.6 points higher. Over time, the developmental curves are also different. Whereas there seems to be a relatively steady rate of growth for the White children, the developmental trajectory for the African American and Latino children is distinctly nonlinear; their growth rates are flatter until around age 4 and then take off at a faster rate (i.e., a sharper curve), with the lines for the three groups starting to converge.

Children's development was found to be related to: (a) their experience of economic hardship (with children experiencing the most persistent hardship having the poorest developmental outcomes—lower cognitive and social functioning and slower rates of growth), (b) maternal depression, and (c) inappropriate parenting. There was no significant relationship between development and certain family stressors such as parental conflict, family instability, or substance abuse by family members.

■ Stability and Change in the Parenting Skills of Mothers and Economic Development of Low-Income Families

Jean Layzer, Robert St.Pierre

A longitudinal database from the national evaluation of the Comprehensive Child Development Program (CCDP) was used to examine developmental patterns in parenting skills and economic self-sufficiency in a large sample of poverty-level families. The sample consisted of approximately 2,000 families randomly assigned to the control group in the CCDP national impact evaluation that was conducted in 21 low-income communities in 18 states. To be eligible for the study, families had to be below the poverty level and had to include a pregnant woman or a child less than 12 months of age.

The national CCDP evaluation called for annual, repeated measures of maternal parenting skills and family economic outcomes between the time that the evaluation began and the focus child's fifth birth date. The database included up to five measurements of the parenting skills of mothers using measures such as the Adult-Adolescent Parenting Inventory, the Nursing Child Assessment Teaching Scale, and a survey version of the HOME scale, as well as the economic development of families using measures such as educational progress and status, total household income, and weekly wages. Several measures of the nature and amount of employment and of the extent of dependence on public assistance were also used.

Linear and nonlinear growth curve analyses were used to analyze data collected at multiple points in time, while OLS regression was used to analyze the end-of-study status of families. Results indicate clear patterns of growth and change in the parenting skills of low-income mothers and in the economic development of poverty-level families.

■ Fathers and Father-Figures of Low-Income Preschool Children

Joan E. McLaughlin, Cristofer Price

The role of fathers in children's lives has long been considered important, but there has been relatively little attention paid to fathers in child development research. The lack of information on fathers is particularly acute for low-income families, despite the obvious need for this information in developing policies related to welfare and child support, and in helping to understand ways to alleviate the effects of poverty on child development. The data set for the evaluation of the second group or cohort of the Comprehensive Child Development Program (CCDP) provides an opportunity to look at household composition, provide some descriptive information on fathers, and look at mothers' and fathers' perceptions of the father-child relationship.

In the Cohort 2 CCDP evaluation, we collected data from a sample of over 2,000 families with a preschool focus child in 10 sites across the country. As part of the data collection, we obtained information from the primary caregiver (typically the child's mother) on a variety of issues related to the child's father or mother's resident partner. We also conducted a separate interview with about 430 fathers or men that were considered by the mother to be "like a father" to the child. Families were recruited into the program when the child was an infant, and data were collected when the family had been in the program for 1 year and when the child reached 2 and 3 years of age. Except when noted, the data presented here are limited to the 2-year data collection point.

The households in our sample were configured in the following way:

1. There were 2,192 children living at the year 2-data collection period. Of these, 36% lived with a father or mother's partner (f/mp group). The largest group of these are those that live with their biological father (28%) and the two small groups of those that live with a stepfather (3%) or mother's partner (3%). Mothers with partners were asked to distinguish which of these partners were like fathers to the child. Eighty-one percent of them were identified in this way.

Children living with their mother and father or mother's partner varied considerably by race. Only 22% of African American, compared with 56% of White and 63% of Latino families lived with a father or mother's partner. In 95% of these Latino families, the f/mp was most likely to be the biological father. Among White and African American participants, this individual was the biological father in about 80% of the cases.

Regarding household configuration, we were interested in seeing whether or not the group without any father or mother's partner had any adult males living with them who could potentially serve as male support for the mother or child. We found that 15% of these children had other related adult males living with them (e.g., grandfathers, uncles). Only 5% of the mothers said that there was someone living with them whom they considered to be like a father to the child (related or unrelated).

As a next step, we looked at stability of the presence of a father or father figure over the early years of a child's life using 3 years of data. We found that 53% of the focus children never had a father or male partner in the home, 22% consistently had their biological father present for 3 years, and about 2% of the children had a stepfather, foster father, or adopted father or mothers' partner present for the first 3 years of life. The remaining 25% had one or more of these father/father figures come in or out of their lives during this time.

We looked at some characteristics of those men and families in the f/mp group. Sixty-three percent of the f/mp had a diploma, certification, or license. Seventy-four percent were employed (63% full-time and 11% part-time). We also looked at whether the income of families with f/mps was better than those without f/mps. We found that in this sample, a f/mp boosted income about 40%, from $10,000 to just under $14,000 per year. The presence of a f/mp also made it less likely that the household received government assistance (i.e., AFDC, food stamps, government housing).

We also asked some questions about biological fathers who did not live with the children in order to learn a little more about them and their relationship with the child. We found that 50% of the biological fathers lived in the same neighborhood, city, or area as their children, so there was potential for contact. Thirty-seven percent of the nonresident biological fathers saw their children at least once a week.

In the interviews with mothers, we asked a number of questions about their perceptions of the relationship between the children and the men that are considered to be "like fathers to the child." We also asked similar questions to those men we were able to interview separately. The results presented here are the father/father figures' responses, and, where noteworthy, comparisons with the responses obtained from the corresponding interviews with mothers are shown.

Regarding the father/father figure's response to the question "How often does the father/father-figure look after the child," there is a fairly high percentage of these fathers that look after the child every day. For those who live with the child, this ranges from 67–82%. Nonresident fathers are less likely to watch the child every day, but 37% of this particular group of fathers that we captured for the interview see their child at least once a week. Mothers' perceptions were generally aligned up with how the fathers' responded.

We asked about the time spent each day by the father/father figure that is just for the child. Both fathers and mothers report that father/father figures spend at least some time each day doing activities that are just for the child. Mothers' partners were somewhat less likely to spend 2 or more hours a day playing with the children (18% vs. 33–57% of the other groups).

When asked about how close they were to the child, about 80% of the father/father figures said they were very close to the child. Mothers' perceptions were generally aligned here as well. Two exceptions to this high ranking were mothers' partner ratings of closeness and mothers ratings on nonresident biological fathers (67% and 60%, respectively).

Of note is that while most of the mothers were satisfied with the amount of time these men spent with the child, most f/mps wished they could spend more time with the child. This varied by type of father-child relationship, ranging from 56% of resident biological fathers to 73% for mothers' partners.

Mothers and fathers/father figures were also asked to report on how much disagreement or conflict there was over how the child is raised and money spent on the child. Each group reported more disagreements about how a child is raised than how the mother or father/father figure spends money on the child. Thirty to fifty percent reported at least some conflict over how the child was being raised. The greatest conflicts were between mother and her partner and mother and the nonresidential biological father.

Roughly 10–30% reported conflict over how money is spent. Mothers and nonresident biological fathers reported more conflict, however, with mothers reporting 51% and fathers reporting 34% conflict over how the father spends money on the child.

Mothers and father/father figures were asked about their expectations for their child's attainment and performance in school. Expectations were high across the board. Eighty-six percent or more thought their child would graduate from high school and over half thought that their child would graduate from college or attend graduate school. In terms of performance, over half thought their child would do very well in school. Less than a quarter believed their child would do average work.

Summary

1. Only about a third of the low-income households in our sample had a father or male partner in the household.
2. Over half of the children did not have any of father or male partner present at any time during the first 3 years of life. For 25%, there was at least some instability, with at least one father or male partner coming in or out of the household during this time.

3. Of the nonresidential biological fathers, over 50% live within the same area as the child, so there is some potential for contact and support.
4. Of those men who were fathers or like fathers to the child, they cared for the child, played with them, felt close to them, and wished that they could spend more time with them.
5. Mothers and father/father figures believe in their children's abilities, and in spite of what we know of the challenges faced by children in poverty, they believe the children will reach their educational goals and do well in school.

ACYF, Head Start Bureau Poster Symposium: Early Head Start

The Early Head Start (EHS) evaluation is a 5-year study of families with infants and toddlers who were enrolled in the EHS program beginning in 1995. The evaluation consists of a national study plus 17 local research sites where data are being collected to enrich and expand the national findings. The objectives of the study are to: create a system for continuous program improvement through formative feedback; conduct a rigorous cross-site impact study evaluation; encourage new program research; and create a foundation for subsequent longitudinal studies. ACYF designed this set of research and evaluation initiatives to establish the efficacy of the EHS program and to contribute new knowledge to the field on factors that influence the developmental progress of low-income infants and toddlers and their families. The two-tiered evaluation approach allows for an assessment of EHS in the context of different populations and communities. As designed, the national evaluation will answer questions about the effects of programs and program implementation, and the local studies will add information about mediators and moderators of program effects. The sample for the study includes approximately 3,000 families who were randomly assigned to treatment and control groups. Child and family data are being collected via child assessments, parent interviews, videotaped observations, staff questionnaires, child care provider interviews and observations, and the Head Start Family Information System (HSFIS) Application and Enrollment forms.

EHS local and national evaluations were presented along with data from a collaborative study regarding fathers and a study of welfare reform. A variety of information was presented by sites in the areas of: adult attachment, poverty, culture, adolescent motherhood, health care, engagement in EHS, child response to intervention, early language development, risk and resilience, mental health, and mother-child interaction. Local and national researchers were present to discuss the variety of design and methodological issues in their work.

■ Predicting Program Use and Acceptance by Parents Enrolled in Early Head Start

JoAnn Robinson, Robert Emde, Jon Korfmacher

The purpose of this investigation is to examine how well antecedent background characteristics of parents enrolled in the Clayton/Mile High Early Head Start program predict their response to and use of the program during its first 16 months of operation.

Participants were 77 mothers enrolled through random assignment in the Clayton/Mile High Early Head Start program, a home-visiting program that also encompasses center-based child activities. Participants were mothers enrolled at any time during pregnancy until the child was 12 months of age.

Background characteristics collected at intake into the program included: (a) sociodemographic and cultural characteristics, such as maternal age, marital status, parity, educational level, household density, gang involvement, ethnicity/race, and primary language spoken; (b) features of mothers' psychological resources, including mastery, depression, and intelligence, and stress level; and (c) relationship orientation, measured by the Simpson Relationship Inventory.

Program process variables were measured through the record-keeping system used by home visitors. Using an "encounter" form that was filled out after each home visit, home visitors rated mothers on their level of emotional engagement with the visitor during the visits. In addition,

these forms were used to track the number of completed home visits. An aggregate, categorical variable was used to classify mothers by their level of emotional engagement and the amount of participation (number of completed home visits).

Our initial analyses compared the randomly assigned treatment and control groups on the three variable sets defined above. T tests showed no significant differences for either features of mothers' psychological resources or her relationship orientation between control and treatment groups, indicating that the random assignment was successful with respect to these measures. We next examined the associations between mothers' use of home visit services and their characteristics at intake. Of the 77 women enrolled in the first 16 months, 13 received no visits. Nearly half the sample (37) received 10 or more visits during this time. Preliminary analyses showed no linear relationship between initial characteristics and mothers' use of services. Further analyses will be conducted to explore specific patterns of usage within subgroups.

■ Examining the Child's Experience in an Early Head Start Program

Jon Korfmacher, Paul Spicer, Robert Emde

The purpose of this study is to examine how children enrolled in a center-based, Montessori Early Head Start program respond to the classroom environments, using both quantitative and qualitative sources of data. The subjects are 3 male children (age range: 15–27 months) who were selected as case studies to show patterns of change over approximately 1 year in how children respond to the classroom environments. One was chosen to demonstrate generally improving progress within a classroom, one to demonstrate a child with a somewhat negative trajectory within a classroom, and one to illustrate how the transition between classrooms can influence child behavior.

The four dimensions of study are: (a) Interest and orientation to classroom materials; (b) Frustration and negative emotion to limit-setting; (c) Interest in and use of the caregiver; and (d) Social interaction with peers. Sources of data were summary measures from rating scales filled out by teachers on a weekly basis and ethnographic field notes. Results demonstrate the individual variation that children show in their behaviors within the classroom, and suggest ways that qualitative and quantitative data can complement each other.

■ Pursuing the American Dream: Needs and Aspirations of the Working Poor

Shavaun Wall, Harriet Liebow, Christine Sabatino, Nancy McK. Smith, Nancy E. Taylor, Elizabeth Timberlake

PRESENTERS: Shavaun Wall, Elizabeth Timberlake

The families who applied to the United Cerebral Palsy Early Head Start program in Alexandria, VA, were primarily "working poor," with over 70% having one or both parents employed. (Analyses are based on the first 91 families to apply). The families were diverse culturally and include almost 50% immigrants and 28% low-ranking military. Immigrants were from Central and South America, Asia, Eastern Europe and Africa. US-born families include African Americans, Native Americans, and Caucasians. Bicultural traditions were also reported by 10% of the families. The parents were older and better educated than in some other EHS sites, with most falling between 20 and 39 years old, and only 8% of mothers and no fathers were in their teens. Two thirds of the mothers had a high school education or beyond. Many focus children lived

with both birth parents (close to 60%). Less than 20% of the focus children lived just with their mothers. At the time of application, 9% of the parents reported a developmental delay or disability for the focus child (mean age of focus children equal to 10 months, although 16 were pregnant applicants with the focus child unborn).

While most families received food stamps at the time of their application (59%), less than one third received other services available for people in poverty. Surprisingly few availed themselves of cash benefits (e.g., only 22% received Aid for Dependent Children). Most families received only one or two services. The low rate of services may be related to fears that immigrant or military families have about accessing services as well as traditional barriers to obtaining community resources noted in the literature about families in poverty. Almost all families rated their resources as less than adequate (97%), with immigrant families scoring the lowest. The families perceived their greatest needs in the areas of child care, money, dental care, jobs, and social support (84% to 64% reporting these in descending order). About half of the families also reported needs regarding information about parenting, information about participating in community groups, and needs to obtain clothes, medical care, toys, dependable transportation, and better housing for their families. Correspondingly, the goals of the families emphasized obtaining more education (90%), acquiring new job skills (70%), and having more income (89%), plus many expressed a goal of obtaining better housing (74%).

Stresses unique to military families included the hardships for families presented by tours of duty (acknowledged by 100% of the sample) and the difficulties separating family or private life from military life. Stresses on immigrants included the losses associated with leaving family members behind and difficulties in accepting new customs. Some acknowledged a sense of loss of cultural identity.

In future analyses, we will continue to identify patterns of needs and resources by ethnic and occupational groups. We will also explore how EHS families reduce barriers and enhance their children's development along with the wellbeing and assets of their families.

■ Home Visiting: What Are the Questions? How Do We Answer Them?

Susan L. McBride, Carla A. Peterson

Despite the pervasive use of home visiting as a model of service delivery for preventive and intervention efforts with young children and their families, the nature and content of home visits that are actually conducted have rarely been documented. Research often assumes home visiting to be a homogenous treatment provided by program staff and received by families in a homogenous manner. Recently Guralnick (1997) has suggested that we need "second generation" research that investigates the specific aspect of interventions associated with outcomes. New methodologies are necessary for documenting the specific intervention provided during a home visit if specific intervention strategies responsible for family and child outcomes are to be identified.

The presentation described the efforts being made to document various aspects of home visits being provided in an Early Head Start program in central Iowa. Several strategies have been developed, including: (a) observation of the process and content of home visits, (b) assessment of the provider-family relationship, (c) ratings of the engagement of children and families in the intervention process, and (d) reports of critical incidents by families and providers. The primary objective of the study is to describe the nature and content of the home visit intervention. The presentation included: (a) an explanation of the research goals and implementation issues,

(b) findings to date that describe the intervention processes occurring in the EHS program, and (c) dilemmas associated with conducting field-based research.

Data were collected using the Home Visit Observation Form. This partial interval observation system requires the observer to code: (a) primary interactors (e.g., parent and child or parent and interventionist), (b) content of the interaction (child development, child health and safety, family functioning, etc.) and (c) nature of the home interventionist's role (observing, asking or giving information, supporting parent child interaction, etc.) every 30 seconds. Data are collapsed across intervals to indicate the percentage of time each category of behavior occurred during visits.

Findings to date indicate that the content and process of home visits are related to the role of the home interventionist. Child Development Specialists (CDS's) are more likely to address child development issues while Family Development Specialists (FDS's) focus on family issues such as relationships, employment, or education. Both the CDS's and FDS's primarily support interactions with parents or other adults (over 50% of the time). The amount of time devoted to supporting parent-child interaction by modeling or coaching parent-child interactions was limited. In summary, the process and content of home visits appear to be related to assumed program goals and training of the interventionists.

The next step in data analyses will be to identify risk and opportunity variables associated with families (e.g., mother's age, mother's level of depression). These factors will be used to assess the extent to which they are related to the intervention process variables. Eventually, the relationships between intervention variables and family and child outcomes will be explored.

Reference:

Guralnick, M. J. (1997). Second-generation research in the field of early intervention. In M. J. Guralnick (Ed.), *The effectiveness of early intervention*, (pp. 3-20). Baltimore, MD: Paul Brookes Publishing.

■ Perspectives on Risk and Resilience: Comparing Quantitative and Ethnographic Methods

Jean Ann Summers, Jane Atwater, Judith Carta, Mary Grace Brown

The purpose of this presentation is to investigate how quantitative and ethnographic measures of families may both differ and converge in developing perspectives of family risk and protective factors. The study used the Early Head Start program outcomes as an organizing framework for understanding risk and protective factors which might be indicated by either methodology. Interview transcripts from the ethnographic study of 13 families were coded and scored to identify whether the family appeared to have either strengths or weaknesses in each of 18 program family outcomes. Using measures from the quantitative study intended to approximate these outcomes. Individual scores for the same 13 families were also used to rate the family as having strengths or weaknesses in those outcomes. The scores derived from each methodology were compared in each of three broad program outcome areas (parent-child outcomes, self-sufficiency outcomes, and family support/mental health outcomes) to identify agreements and disagreements. Interpretations of discrepancies and similarities between the two methods are discussed.

■ University of Missouri Early Head Start Local Research

Kathy R. Thornburg, Jean Ispa, Mark A. Fine

Our local research project involves an analysis of interviews from 9 case families in the Early Head Start (EHS) program in Kansas City, Missouri. Mothers (and others involved in the child's life, when available) are interviewed three times a year and complete a brief phone interview three times a year. As of July, 1998, we have completed the fifth interview on all of the mothers. Our inquiry focuses on six key questions, including: (a) What EHS factors have had an impact on child and family development and how have these factors had an impact? (b) What are the intrapersonal factors involved in mothers' transition to parenthood—as they move from thinking primarily about their own personal needs to placing priority on their children's needs? (c) How do relationships with family/extended family/friends support and/or hinder children and parents' development? (d) What are mothers and fathers' thoughts regarding child development? How does their understanding of child development influence their childrearing practices and behaviors? (e) How do mothers' involvements with work, school, and other societal institutions impact their well-being and their children's? and (f) How does the larger sociocultural environment affect the family and the child's well-being? Results pertaining to each of these questions are presented.

■ Pathways Project: Research Into Directions for Family Health and Service Use

Rachel F. Schiffman, Cynthia L. Gibbons, Mildred A. Omar, Thomas M. Reischl, Hiram E. Fitzgerald, Dennis R. Keefe, Marjorie J. Kostelnik, Holly Brophy-Herb

Family health is an outcome which may be influenced by participation and time of enrollment in the Early Head Start program (EHS). Family health may also be a predictor of service use. Of interest are the pathways that families may take at different times with respect to their health and use of services. The research questions are: (a) What are the characteristics associated with family health? (b) What is the association of EHS participation and time of enrollment into EHS to family health over time? and (c) Do family health, EHS participation, and time of enrollment into EHS predict the type, combination, use of, and retention in services and programs at different times?

A longitudinal experimental design combining qualitative and quantitative data collection and analytic approaches will be used. There will be three methods of data collection: family observation/surveys, parent interviews, and record reviews. We will enroll 150 families who will be randomized (75 intervention and 75 control) according to the EHS national evaluation criteria. We will collect data for the family observation/surveys and the chart reviews for the entire sample at enrollment and at 14, 24, and 36 months of the child's age. The parent interview and record data will be collected at enrollment, at 6, 15, and 26 months after enrollment, and at exit from the program.

A typology of family health will be developed. The characteristics that define health for each of the components measured as well as a composite of the family that identifies the family health category (health promotion, maintenance, restoration, or chaos) will be determined. The first stage of data analysis will focus on documenting or verifying the equivalence of the participants randomly assigned to the intervention group and to the control group. As much as possible, we will examine the extent to which uncontrolled selection factors are related to the baseline assessments using theory-guided (hierarchical) regression procedures. The second stage of analysis will focus on group differences in the amount and type of family health and support

services that the families received from EHS and other programs. We will employ MANOVA procedures for these checks. The third stage of analysis will focus on the second set of research questions and hypotheses—those that address the impact of participation in EHS and family health. Repeated Measures ANOVA or linear regression procedures will be employed to examine the longitudinal impact of the program. We will employ data analytic procedures which will test for a "Program by Age of Enrollment" interaction effect. The fourth stage of data analysis will address the third set of research questions and hypothesis—those that explore the factors related to successful participation in EHS and other program-related health and family services. We will examine multiple structural equation covariance models (e.g., cross panel models) that estimate the longitudinal correlation between program participation and family health levels and evaluate how well these structural equation models "fit" the longitudinal correlation at different points.

■ Maternal Mental Health, Self-Efficacy, and Locus of Control as Predictors of Parenting Interactions in Low-Income Families

Catherine Tamis-LeMonda, Mark Spellmann, Poonam Ajuda, Joanne Roberts, Jacqueline Shannon

Over the past two decades, there has been an increasing interest in the ways that mothers' psychological functioning influences the quality of mother-infant interactions. For example, maternal depression has been found to lower mothers' feelings of self-efficacy and to be associated with externalized loci of control. In turn, decreased self-efficacy and an external locus of control have been found to predict decreased maternal responsivity, greater negative affect, and heightened intrusiveness in parenting. Mothers who face chronic poverty are found to be especially at risk for mental health problems and lowered feelings of competence regarding their parenting abilities, and have been shown to demonstrate lowered sensitivity and involvement when interacting with their young children. As such, poverty is thought to ultimately affect children's development through its link with maternal psychological and behavioral factors.

The present investigations examined relations between mothers' depression, self-efficacy, and locus of control and examined relations between these indices of maternal psychological functioning and mother-infant interaction in a group of low-income mothers. In this study, we examined: (a) relations among maternal depression, self-efficacy, post-traumatic stress, and locus of control and (b) relations between maternal depression, self-efficacy, post-traumatic stress, and locus of control and qualities of mother-infant interaction.

Participants were 50 culturally diverse infant-mother dyads. All families were of low social economic status as defined by eligibility for Aid to Families with Dependent Children. Mothers ranged from ages 15–36, with a mean age of 22; the vast majority of mothers were under 19 years of age. All infants were between the age of 6–9 months. Fifty-six percent of the children were boys and 44% were girls. Seven of the dyads had incomplete data sets for various reasons and were not considered in the analyses.

Mothers were visited by two researchers in their homes. Dyads were presented with a standardized set of age appropriate toys: a rattle, an infant mirror, a ball with multicolored beads inside, nesting animals, a toy pot with spoon and lid, four pieces of fruit, and a puppet.

Mothers were asked to interact with their children as they normally would. They were asked to face the camera and ignore the researchers while filming. Mothers were also asked not to use the other toys present in the house or give their infants bottles or pacifiers during filming. Mothers were given $20 and a copy of the videotape for participating in the study.

Coding of the Mother-Child interaction was done by a single researcher with a second researcher coding every fifth tape. Reliability ranged from (r =.93-.81) across the 39 variables

considered. Coding was based on 21 mother, 15 child, and 3 dyad variables. All variables were coded on a 5-point Likert scale, with 5 representing the highest and 1 representing the lowest score on each variable.

Maternal variables included: (a) positive affect, (b) negative affect, (c) intrusiveness, (d) responsiveness, and (e) involvement with child. Infant variables included (a) positive affect, (b) negative affect, (c) positive touch, (d) negative touch, (e) responsiveness to mother, and (f) emotional regulation. Dyad variables included (a) mutual enjoyment of interaction, (b) mutual communication, and (c) reciprocity of interaction.

At the time of videotaping, mothers were asked to complete a packet of self-administered questionnaires. This packet included: (a) Teti's Scale of Maternal Self-Efficacy (e.g., "When your baby is upset, fussy or crying, how good are you at soothing him/her?"), (b) Sirignano's Maternal Locus of Control Scale (e.g., "When I am able to dress my child easily it is because..."), (c) The Center for Epidemiological Studies Depressions Scale (CES-D; e.g., "I think my life has been a failure."), and (d) Horowitz' Impact of Events Scale (IES; PTSD symptoms; e.g., "I thought about it (traumatic event) when I did not want to.").

The psychometric properties of the scales were examined using factor analysis and reliability analysis. Correlations among the four psychological variables were examined. Correlations between measures of mothers' psychological functioning and parent-child interactions were assessed.

In the first stage of analyses, we explored the construct validity of the parenting dimensions that were expected to emerge from the ratings of maternal interaction. Items were factor analyzed with respect to four constructs in accordance with our a priori conceptualization of the measures: (a) Maternal Affect, (b) Maternal Sensitivity, (c) Maternal Involvement, and (d) Maternal Didactic. Results of the factor analyses supported the construct validity of these four scales. Kronbach's alpha (range = .77 to .92) established the internal consistency of the four scales. Because infant measures did not form reliable factors, we identified a subset of measures to be included in further analyses.

In the next stage of analyses, the construct validity of the four psychological measures (CES-D, IES, Self-Efficacy, and Locus of Control) were examined through Exploratory Factor Analysis. The anticipated factor structures emerged for the CES-D, the IES, and the Efficacy Scale. The CES-D and the Efficacy Scale were unidimensional, and the Numbing and Flooding dimensions of the IES emerged as distinct factors. The factor structure of the Locus of Control Scale did not accord with a priori expectations. That is, internal and external locus of control dimensions did not emerge. Rather, experiencing one's self as good at mothering tasks loaded with finding the tasks of parenting to be easy. Experiencing one's self as poor at mothering tasks loaded with not trying hard at parenting. The internal consistency of all scales was very good, alpha > .80. In an analysis of relations among the four maternal psychological variables, as expected, the various measures related somewhat consistently to one another.

In the final stage of analyses, we examined relations between maternal psychological measures and qualities of mother-infant interaction. In general, few of the psychological measures related to maternal behaviors. Maternal depression related inversely to mutual communication in the dyad, $r = -.24$ ($p<.05$), and to dyadic reciprocity, $r = -.30$ ($p<.05$). In addition, mothers who considered parenting to be easy and rated themselves as being good at mothering scored higher on maternal involvement, $r = .29$ ($p<.05$) and on maternal sensitivity, $r = .27$ ($p<.05$). Mothers who rated themselves as not being good at the task of parenting and not trying hard at parenting scored lower on positive affect, $r = .29$ ($p<.05$).

Similarly, psychological measures related to only certain child measures. Flooding related inversely to both positive touch in babies, $r = -.35$ ($p<.05$), and babies' responsiveness to mothers, $r = -.31$ ($p<.05$). Mothers' self-efficacy related positively to infants' emotional regulation, $r = .27$, ($p<.05$), and maternal depression related inversely to infants' positive touch, $r = -.25$ ($p<.05$). Finally, mothers who rated themselves as not being good as parents and not trying

hard at parenting had babies who exhibited less positive touch r = .-.62 (p<.01) and were less responsive to their mothers, r = -.28 (p<.05).

Summary

1. The construct validity and internal consistency of four measures of maternal psychological functioning were supported.
2. The construct validity and internal consistency of four dimensions of maternal interaction style were supported.
3. In general, measures of maternal depression, self-efficacy, locus of control, and two dimensions of post-traumatic stress (i.e., numbing and flooding) covaried.
4. Associations between measures of mothers' psychological functioning and qualities of mother-infant interaction were not as robust as had been expected, although certain meaningful relations did emerge. Locus of control related to maternal affect, sensitivity, and involvement. Depression related to measures in the dyad. All four measures of psychological functioning related inversely to infant behaviors, in particular to infant positive touch and responsiveness.
5. In a longitudinal follow-up of these dyads, we are currently examining predictive relations between measures of mothers' psychological functioning and mother-infant interactions and toddlers' cognitive, linguistic, and social-emotional achievements during the 2nd and 3rd years of life. We are also assessing direct and indirect contributions of fathers to the growing competencies of these children.

■ Social Support and EHS Families: An Integration of Quantitative and Ethnographic Findings

Beth Green, Carol McAllister

This poster featured findings from baseline interviews conducted with research families at the Pittsburgh EHS site concerning families' needs for, satisfaction with, and availability of social support of various kinds, including tangible supports (for example, help with chores and children) and emotional support. It also presented an ethnographic analysis of more detailed issues related to the social support networks of four case study families.

The two analyses provide complementary looks at the characteristics of support networks in EHS families. While the quantitative data provide an overarching summary of how many people are in social networks, how much support parents need, and how satisfied they are, the ethnographic discussion raises important concerns and questions about who makes up these social networks, the nature of social connections, the sometimes negative consequences of interpersonal relationships, and the role of informal support systems for the parent-child dyad.

There are several important points that should be highlighted from these analyses. First, it is clear that while there is large variation in the level of need for support that families have, there is clearly a significant number of families who have extremely high needs for support, but whose support networks are small or nonexistent. This suggests a strong need for the program to provide additional support to families and to help them further develop and use their own networks. However, it is notable that case study families were reluctant to place the program in their social support networks. At the 14-month quantitative interview, as well as in future ethnographic interviews, we will be asking parents about the kinds of support provided by the program, and will be able to explore this issue further.

Second, both analyses suggest that the availability of people to provide support does not always lead to adequate or satisfactory support in the face of specific needs. As the ethnographic

discussion points out, social relationships can create a sense of burden and strain as well as provide important benefits. This may account for the quantitative finding which suggests that having larger networks does not lead to greater satisfaction with support. This variable (the potentially burdensome aspects of support) has been added to the quantitative interview at 14 months and will be explored in the third ethnographic interview as well.

We should emphasize that both of these analyses are preliminary; we will have more data, both quantitative and qualitative, to share in future presentations. We are also very interested in working with the program to ensure our data collection and analysis in relation to the construct of social support contributes to program efforts to become a truly child-focused program with a refining of this key construct to highlight its meaning for parenting and the parent-child relationship.

■ Level One Qualitative Coding of Adolescent and Young Adult Mothers' Perceptions of Transition to Motherhood: A Window on Risk and Resilience Factors Associated With Adolescent Pregnancy

Susan G. Pickrel, Adena Meyers, Michael Brondino, Richard Faldowski

Although adolescent childbearing had been prevalent in this country throughout history, the issue has drawn significant attention from policy makers and researchers primarily during the past three decades (Furstenburg, Brooks-Gunn, & Chase-Lansdale, 1989; Luker, 1996). Numerous studies have documented associations between adolescent parenthood and a variety of deleterious outcomes for both mother and child. Adolescent mothers are more likely than their same-age peers to drop out of school, receive welfare, and be single parents (Coley & Chase-Lansdale, 1998). Additionally, research indicates that the children of adolescent mothers are at a disadvantage in terms of cognitive and behavioral functioning (Furstenburg et.al., 1989). Longitudinal evidence suggest that the negative consequences to early childbearers may diminish over time but that the disadvantages observed in their children tend to persist and may even increase as they grow older (Furstenburg, Brookes-Gunn, & Morgan, 1987; Coley, Chase-Lansdale, 1998).

Although adolescent childbearing is associated with numerous problematic outcomes, a growing body of literature argues that early parenthood per se is not the primary cause of these problems. It has been suggested that for some adolescents, pregnancy and parenthood may actually constitute an adaptive, development-enhancing experience, particularly in cases where other pathways to adulthood and autonomy are not available because of socioeconomic constraints (Burton, 1990; Geronimus, 1992). While these authors argue convincingly against the assumption that adolescent childbearing is always a negative experience for the mother, it is still concerning that the children of adolescent mothers seem to experience persistent developmental disadvantages.

Are there characteristics of adolescent mothers which mediate the effects of adolescent parenthood on future offspring's development? Sommer, Whitman, Borkowski, Schellenbach, Maxwell, and Keogh (1993) argue that adolescent mothers who are not cognitively prepared for parenthood may be more likely to show deficits in their parenting abilities and as a result their children may be at increased risk for cognitive and behavioral problems. These authors found that although adolescent mothers exhibit lower levels of cognitive readiness than adult mothers, there was still considerable variability in cognitive readiness among adolescent mothers, and this was predictive of differential parenting behaviors. These findings suggest that adolescent parenthood may be an adaptive choice for some adolescents, but not for others, and that the mother's level of cognitive readiness may mediate the effects of early parenthood on the offspring.

The present study gives us the opportunity to examine young mothers' experiences in the transition to parenthood from their own point of view. A sample of 150 mothers aged 12 to 25 years old enrolled in an Early Head Start program have completed a semistructured, qualitative interview designed to gather adolescent and young adult parents' thoughts about pregnancy and emerging motherhood as well as functioning in multiple life areas. We have identified ways in which some adolescents report the experience as a positive one. Specifically, some indicate that some of their own needs are met by their children, and several others describe the transition to parenthood as contributing to their own maturity and adult identity. These descriptive data will eventually be linked with child and parent outcomes, including parental level of education, employment, and child developmental scores on the Bayley, giving us new insights into the potentially adaptive aspects of adolescent parenthood.

References

Burton, L. (1990). Teenage childbearing as an alternative life-course strategy in multigenerational Black families. *Human Nature, 1*, 123–43.

Coley, R. L., & Chase-Lansdale, P. L. (1998). Adolescent pregnancy and parenthood: Recent evidence and future directions. *American Psychologist, 53*, 152–66.

Furstenburg, F. F., Brooks-Gunn, J., & Chase-Lansdale, L. (1989). Teenaged pregnancy and childbearing. *American Psychologist, 44*, 313–20.

Furstenburg, F. F., Brooks-Gunn, J., & Morgan, S. P. (1987). *Adolescent mothers in later life.* New York: Cambridge University Press.

Geronimus, A. T. (1992). Clashes of common sense: On the previous child rearing experience of teenage mothers-to-be. *Human Organization, 51*, 318–29.

Luker, K. (1996). *Dubious conceptions: The politics of teen pregnancy.* Cambridge, MA: Harvard University Press.

Sommer, K., Whitman, T. L., Borkowski, J. G., Schellenbach, C., Maxwell, S., & Keogh, D. (1993). Cognitive readiness and adolescent parenting. *Developmental Psychology, 29*, 389–98.

■ Mothers and Fathers in Utah's Early Head Start

Lori A. Roggman, Lisa K. Boyce

A primary goal of Early Head Start (EHS) is to support the optimal development of infants and toddlers. In Utah, the EHS program strives to do this by promoting responsive parenting by both mothers and fathers. Through sensitivity to the cues and developmental needs of the infant, responsive parenting supports the infant's secure attachment and playful exploration of the world. However, some parents may be faced with limitations that make it difficult for them to provide responsive parenting. For both mothers and fathers, EHS is concerned with helping parents overcome the limitations of their knowledge, attitudes, well-being, and social support. The most appropriate strategies for working with parents may depend on the variability and interrelatedness of these limitations.

As part of the local research at the Utah EHS, baseline interviews were conducted with both mothers (n = 165) and fathers (n = 114). Questions addressed knowledge of infant development, perceptions of parenting stress, attitudes about close relationships, feelings of depression and mastery over their lives, and use of social support. Measures included: Knowledge of Infant Development Inventory, Adult Attachment Scale, Center for Epidemiological Studies-Depression, Pearlin Mastery Scale, and F-COPES Social Support.

The results showed that mothers knew more about infant development and reported more depression than fathers did. The patterns of interrelatedness among measures were similar for

mothers and fathers, except the relation between depression and relationship attitudes, which was significant for mothers but not fathers. For both mothers and fathers, measures of their knowledge of development, attitudes about relationships, feelings of mastery, and use of social support tend to go in the same direction.

As with any correlations, there are no indications of what causes what. Nevertheless, the interrelatedness among measures suggests that parents facing one limitation are also likely to be facing others. The same pattern suggests that parents who are psychologically healthy are also more likely to feel in control of their lives, know about infant development, and make more use of their social support resources. Whether these "limitations" actually limit these parents' responsiveness is not yet known; although it is suggested by other research. Later observations of parents' responsiveness to their infants will allow for further research to test this assumption.

These results from Utah's EHS parents may not be generalizable to parents in other areas. The population in Utah is influenced by the dominant religion (LDS or Mormon) which places a strong emphasis on parenting and mastery and provides extensive social support networks. Comparison data from other research sites may help clarify the relations among limitations to responsive parenting that may challenge other EHS programs. As EHS programs develop strategies for helping parents, sensitivity to parents knowledge, attitudes, well-being, and social support may reveal needs for extra assistance to overcome limitations to responsive parenting.

■ Patterns of Verbal and Nonverbal Communication Between Mothers and Their 14-Month-Old Children

Barbara Alexander Pan, Catherine E. Snow, Meredith Rowe

One of the outcomes Early Head Start (EHS) is designed to impact is children's language development. Children entering Head Start tend to have smaller vocabularies than the general preschool population (Vernon-Feagans, 1996) and language skills are highly predictive of children's later academic success (Beals, DeTemple, & Dickinson, 1994). Some explanations for social class differences in vocabulary size observable by the time children enter preschool center on amount and style of talk addressed to children (e.g., Hart & Risley, 1995). Other studies note wide variation in interaction styles within working class families (DeTemple & Snow, 1996). The present study was designed to investigate how early SES-related differences in verbal and nonverbal input (i.e., pointing) are observable and what underlying factors are related to differences in maternal input both across and within social class.

Subjects were 20 middle-class mothers and their 14-month-old children from a New England sample (Snow, Pan, Imbens-Bailey, & Herman, 1996) and 20 low-income dyads participating in the national evaluation of Early Head Start. Dyads were observed engaging in book reading and toy play. Mothers completed a checklist about their child's vocabulary, and EHS mothers were interviewed regarding their beliefs about child language development.

Videotaped interaction was transcribed and analyzed, yielding measures of spontaneous language production and communicative gesture. One-way ANOVAs revealed no differences between middle-class and low-income children in amount or intelligibility of talk. However, differences were observed in maternal amount of talk ($F = 5.14$, $p < .02$) and maternal pointing ($F = 4.09$, $p < .05$) as well as in child pointing ($F = 4.41$, $p < .04$), suggesting that by 14 months children are already being socialized to engage more or less intensively in communicative interaction.

Investigation of within-group variation indicated that EHS mothers who pointed more also talked more to their children ($r = .44$, $p < .05$), and their children pointed more ($r = .51$, $p < .02$). Maternal pointing was also related to mothers' estimations of their child's receptive vocabulary

($r = .47$, $p < .04$). In contrast, middle-class mothers who pointed more did not necessarily talk more themselves, although their children did ($r = .51$, $p < .02$), and in this group maternal pointing was unrelated to estimations of child receptive vocabulary.

All 20 EHS mothers reported that they talked to their children "a lot" during the preverbal period, though for varying reasons. Mothers above the group median level of talkativeness tended to report affective or both affective and pedagogical reasons for talking to their children (e.g., "My son likes it and it helps him communicate."), while those below the group median tended to report purely pedagogical reasons (e.g., "It will help my daughter learn to talk sooner."). These data suggest that while most mothers believe that talking to their children facilitates language development, those who perceive communicative interaction with their children to be pleasurable for both of them are more likely to engage in frequent communicative interaction with them.

References

Beals, D. E., DeTemple, J. M., & Dickinson, D. K. (1994). Talking and listening that support early literacy development of children from low-income families. In D. K. Dickinson (Ed.), *Bridges to literacy: Approaches to supporting child and family literacy* (pp.30–40). Cambridge, MA: Basil Blackwell.

DeTemple, J., & Snow, C. E. (1996). Styles of parent-child book reading as related to mothers' views of literacy and children's literacy outcomes. In J. Shimron (Ed.), *Literacy and education: Essays in honor of Dina Feitelson*. Cresskill, NJ: Hampton Press.

Hart, B., & Risley, T. R. (1995). *Meaningful differences in the everyday experience of young American children*. Baltimore, MD: Paul H. Brooks.

Snow, C. E., Pan, B. A., Imbens-Bailey, A., & Herman, J. (1996). Learning how to say what one means: A longitudinal study of children's speech act use. *Social Development, 5*, pp.56–84.

Vernon-Feagans, L. (1996). *Children's talk in communities and classrooms*. Cambridge, MA: Blackwell Publishers.

■ Familial and Cultural Contributions to Social Interaction, Self-Determination, and Language in Young Hispanic Children in an Early Head Start Program

Joseph J. Stowitschek, Eduardo J. Armijo

Findings to date are presented on how social interaction, self-determination skills, and language development are promoted in their children by disadvantaged, rural, Hispanic families in an Early Head Start program in Washington state. The role of culture-specific values in this process is also presented. Research methodology includes observation, videotape, and interview protocols.

Findings in the area of social interaction/self-determination include: (a) a higher percentage of interaction between adults/peers and targeted children from bilingual families (English/Spanish) than those from monolingual Spanish families; (b) targeted children and adults/peers remain within proximity of each other more frequently in monolingual Spanish families than in bilingual families; (c) a higher percentage of targeted children responded to adult/peer initiations in bilingual families than in monolingual Spanish families; and (d) a higher percentage of continuous activities were observed between targeted children and adults/peers in bilingual families than in monolingual Spanish families.

Observation and interview findings include: (a) a determination by the targeted children's mothers to interact more with their own children than their parents did with them; (b) much of what the mothers know about interaction is reported as based on experiences with their own

children; (c) where present, siblings or peers are observed as being frequently involved in interacting with targeted children; (d) the targeted child is frequently offered choices; and (e) an observance of independence/assertiveness on the part of the target child when not offered a choice.

Parents interviewed also indicated that while love, affection, and respect for others were values passed on to them, their own parents did not play or spend as much time interacting with them as they do with their children. Strong social and choice-making skills were reported as something not passed down to them by their parents. Siblings often took on the role of interacting with or otherwise "watching" the targeted children in many instances. This heavy reliance on siblings is in conflict with some of the statements regarding a desire to spend as much time as possible interacting with their own children. Also, some of the less-acculturated parents (e.g., monolingual, recent immigrants) seem very introverted, as compared to "younger" or more acculturated (e.g., bilingual) parents. They were modest and respectful during interviews, but otherwise kept to themselves or did other things (e.g., cooking, cleaning). They often did not elaborate in their answers to the degree that English-speaking parents did.

Findings in the area of functional language use include: (a) targeted children in bilingual families had a higher response of adult/peer initiations, (b) a higher percentage of continuous activities between targeted children and adults/peers from bilingual families, (c) a higher number of words, sounds, and actions displayed by targeted children and adults/peers from bilingual families as compared to their monolingual Spanish counterparts, (d) a higher number of intelligible works spoken and actions taken by adults/peers from bilingual families as compared to their monolingual Spanish counterparts, and (e) a higher number of both intelligible and unintelligible words spoken by targeted children from bilingual families than by children from monolingual Spanish families.

■ The Story of Mothers Who Have Been Hard to Engage in the Early Head Start Program

Susan Spieker, Joanne Solchany, Kathryn E. Barnard, Margaret McKenna

We asked home visitors to nominate which of the families in their caseloads were "difficult to engage" in the Early Head Start (EHS) program. Ninety families initially enrolled in the EHS program. Sixteen dropped out before providing baseline data. After about 1 year, the home visitors nominated 11 families as "hard to reach." The points of departure that led to identification as "hard-to-reach" families were the extent to which they were unenthusiastic or nonverbal during home visits, missed home visits or failed to reschedule, reluctantly followed through or failed to follow through on suggestions for parent-child interaction, and did not respond to other opportunities or repeated offers to engage in the program.

The "difficult-to-engage" mothers scored similarly to other program families on measures of depressive symptoms, knowledge of child development, relationship style, estimated IQ, marital status, number of moves in the past year, and adequacy of resources as recorded on the Head Start Family Information System (HSFIS). In sum, these "difficult-to-engage" families could not be distinguished at intake with the standard paper and pencil measures typically used.

Next, we considered the results of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984) which classifies the respondent's state of mind with respect to attachment (secure, dismissing, preoccupied, and unresolved). The distribution of AAI classifications for the 11 "difficult-to-engage" cases was significantly different from the rest of the sample. Specifically, the "difficult-to-engage" mothers are more likely to be classified as unresolved with respect to trauma and loss.

We used the women's reports of their life experiences, as told during the AAI, to develop a qualitative database of themes and patterns characteristic of this. The common ground among the themes is that they all reflected the profound sense of loss the mothers felt when they thought about their childhoods.

In our previous association with a Comprehensive Child Development Program (CCDP), it seemed that at least one third of the families engaged readily and made real gains during the course of the program. One third engaged with some difficulty and required a great deal of staff effort to maintain that engagement in order for some gains to occur. One third were extremely difficult to engage at all. This distribution seems to be encountered across various types of programs offering support and services to various groups of people. Our findings indicate that many "difficult-to-engage" families suffer from the effects of major childhood traumas, and that they will not present themselves as particularly needing services. However, they will be a challenge to staff who are not especially trained in mental health issues, specifically in the long-term consequences of abuse, loss, and trauma. As a result, these families will not engage in our programs and are at risk for a continuing cycle of abuse and abandonment.

■ Pearls and Practices to Enhance Early Vocabulary Skills

Colleen E. Huebner, Joanne Solchany, Michelle Funderburke, Marcy Armstrong, Shelley Hibbard, Cherly Hodgson, Gloria Jones-Dance, Maria Kalafatich

Although most children do not speak in words and sentences until some time during the 2nd year of life, these early language skills are built on countless previous conversations with older children and adults.

Studies of social interaction and language have documented several types of early learning experiences that can facilitate vocabulary development. In this Early Head Start project, we have strung these "pearls" of knowledge together to guide our practices with 1- and 2-year-old infants and their families.

The set of practices forms the last module of the Parent-Child Communication Coaching Intervention. The tasks focus on mother-child conversation and book sharing. They include ways of creating and sustaining joint attention, introducing books as a shared activity, and building receptive and expressive vocabulary through verbal games.

■ Resiliency and Adult Attachment in the Arkansas Early Head Start Population

Richard Clubb, Robert Bradley, Leanne Whiteside-Mansell, Mark Swanson

Summary not available at time of publication.

■ Relationship Among Attachment Security, Maternal Sensitivity, and Mother-Child Interaction for Early Head Start Mothers and Their Infants

Carollee Howes, Claire Hamilton, Shira Rosenblatt

Summary not available at time of publication.

■ The Early Head Start National Evaluation Study

John Love, Ellen Kisker, Jeanne Brooks-Gunn, Helen H. Raikes, Louisa Tarullo

Summary not available at time of publication.

■ The Study of Fathers in Early Head Start

Robert Bradley, Catherine Tamis-LeMonda, Lori Roggman, Jean Ann Summers, Paul Spicer, Barbara Alexander Pan, Carol McAllister, Kimberly Boller, Shavaun Wall, Helen H. Raikes, John Love, Jeanne Brooks-Gunn, Lisa Berlin, Kathy Thornburg, Susan McBride, Barbara Greenstein, Hiram Fitzgerald, Cynthia Gibbons, Rachel Schiffman, Jon Korfmacher, Natasha Cabrera, Michael E. Lamb, the EHS Consortium

Summary not available at time of publication.

Head Start Teaching Centers: Four Models of Enhancing Head Start Quality

CO-CHAIRS: Jacqueline Smollar, Diane M. Horm-Wingerd
DISCUSSANTS: JoAnn Knight Herran, Martha Moorehouse
PRESENTERS: David A. Caruso, Lynda J. Dickinson, Julianna C. Golas, Diane M. Horm-Wingerd, Lynn Murphy, Ellen S. Peisner-Feinberg, Janet M. Turchi, John Fantuzzo, Michele A. Strobridge

In 1992, the Head Start Bureau of the Administration on Children, Youth and Families (ACYF) funded 14 Teaching Center Demonstration Projects for 5 years, ending on September 30, 1997. At least one project was funded in each of the 10 geographical ACYF Regions and in the American Indian and Migrant Program areas. The projects were designed to develop and test effective training approaches for Head Start staff in all four major Head Start components—education, health, social services, and parent involvement. The approaches incorporated participatory training activities, such as observation, guided practice, and role-playing. A third-party evaluator working in conjunction with Teaching Center project directors and staff who evaluated each project. Preliminary evaluation findings identified several strategies that were particularly effective in attaining project objectives with respect to staff development. These strategies included: (a) mentoring, (b) integration of training with exemplary Head Start programs, (c) collaborative learning, (d) training of program teams, (e) use of Professional Development Plans or goal setting, (f) providing specialized training for program managers, and (g) individualizing training.

The papers presented provide information regarding the design and effectiveness of four Teaching Center models with respect to enhancing the quality of Head Start services. The papers focus on specific aspects of the Training Centers resulting in positive outcomes, including use of training strategies, such as mentoring, collaborative learning, and team training.

Mentoring is a training approach that uses highly qualified staff to provide guidance and direction to trainees. Mentors provide feedback, answer questions, help trainees plan future activities and set goals, and provide follow-up assistance to trainees after the initial training. Trainees who worked with mentors reported that mentors' helpfulness and skills greatly enhanced the training experience. In addition, access to mentors after training was found to help trainees transfer what they learned to their on-the-job activities.

Collaborative learning refers to the training of small groups of individuals, with group members engaging in discussions, participating in joint activities, and providing feedback to one another after a guided practice, observation, or role-playing activity. Trainees participating in collaborative learning experiences indicated that the approach incorporated them as partners in the training process, and that, consequently, it was an empowering experience.

Team training involved training staff from the same program at the same time to maximize the potential for change in a given program. Teams consisted of teachers, teaching assistants, and parent volunteers, supervisors, component coordinators, and line workers, or other staff with similar job positions. Trainees reported that this approach enhanced staff communication in their programs and resulted in other program staff being receptive to implementing the new ideas learned through training.

The symposium focuses on trainee outcomes relevant to these approaches in four Teaching Centers as well as challenges encountered and lessons learned in implementing these approaches.

■ The New England Head Start Teaching Center: A Regional Approach to Enhancing Head Start Quality

Diane M. Horm-Wingerd, David A. Caruso, Julianna C. Golas

The purpose of the presentation is to describe the design and evaluation of the New England Head Start Teaching Center (NEHSTC), 1 of 14 federally funded programs created to test the efficacy of participatory, hands-on training for enhancing Head Start service delivery. The unique characteristics of the NEHSTC model and its relevance for diverse Head Start settings were explored. Emphasis was placed on the value and efficacy of the model for improving Head Start service delivery as well as the implications for national training and technical assistance programs.

The NEHSTC, designed and implemented by CHILD, Inc., a Head Start grantee located in Rhode Island, provided intensive training to Head Start staff from throughout New England during relatively short periods of residence (3 to 5 days) at the Teaching Center. This format, in combination with the accessibility of the NEHSTC within New England, enabled the participation of large numbers of trainees. Approximately 100 trainees participated in a given year. Typical training topics included: (a) cultural diversity, (b) individualizing services for teachers and family workers, (c) home visitor training, (d) food safety and sanitation, (e) menu planning, and (f) child-initiated activities. Each training session offered by the NEHSTC was composed of four types of learning activities: (a) didactic, (b) group discussion, (c) simulation/role play, and (d) participatory (typically observation and "hands-on" guided practice). The relative amount of time trainees experienced each of these four types of learning activities varied based on the training topic.

The outcome evaluation used a nonequivalent control group design with information collected prior to training and 1 month and 6 months after training. Training and comparison subjects and their supervisors provided information via mailed surveys that were specifically designed to assess knowledge, skills, and competencies in the training content areas.

Analyses of the outcomes for training years 1, 2, and 3 (1993-96) indicated that the NEHSTC training had a significant impact. A 2 (group) X 3 (time) repeated measures analysis of covariance, using the self-ratings collected prior to training as the covariate, indicated a significant difference between the groups over time [Wilks' Lambda $F(2, 128) = 12.23$, $p = .001$]. At 1 month and 6 months after training, trainees reported significant gains in knowledge, skills, and expertise. The comparisons did not.

A similar pattern was found in the analysis of supervisor ratings. A 2 (group) X 3 (time) repeated measures analysis of covariance, using the supervisors' pretraining ratings as the covariate, indicated a significant difference between the groups over time [Wilks' Lambda $F(2,127) = 14.62$, $p = .001$]. At both 1 month and 6 months after training, supervisors rated the trainees as having significant increases in knowledge, skills, and expertise.

Additional data indicated that the NEHSTC was successful in implementing high-quality, participatory training within the context of an ongoing Head Start program. Both the high quality of training and its positive impact on trainees suggest that participatory training should be added to the menu of training options available for Head Start staff.

■ A Systems Approach to Head Start Staff Development: Results of the North Carolina Head Start Teaching Center

Ellen S. Peisner-Feinberg, Janet M. Turchi, Noreen Yazejian

This paper describes the design and evaluation of one Head Start Teaching Center, focusing on the enhancement of classroom quality as a result of participation. A broad approach to measuring quality was taken. This includes the developmental appropriateness and cultural diversity of materials and activities, as well as the nature of teacher-child interactions. This Head Start Teaching Center has taken a systems-approach, providing training to both management and education staff in each program. This approach follows an ecological or systems theory view, which purports that development is affected by all ecological systems within which that development occurs (Sameroff, 1983). Therefore, in order for training to generate improvement in one component of the program (e.g., the classroom), it must also involve other systems interacting with that component (e.g., management practices). While many monitoring and evaluation efforts take a similar approach in considering all components of an early childhood system (e.g., Head Start OSPRI review or NAEYC accreditation), this approach is less widely used in training. At this Teaching Center, each Head Start program participated in training over a 6-month period, with an emphasis on individualized, participatory activities. The Teaching Center worked in conjunction with a host Head Start program to provide opportunities for hands-on training in an ecological setting.

An example of the effectiveness of this training approach for quality enhancement are the changes in participant teachers' classrooms. Different trained observers rated the quality of 77 classrooms (from 21 Head Start Programs) before Teaching Center training and approximately 3 to 4 months after teachers completed training. A series of independent repeated-measures analysis of variance tested differences in pretraining and posttraining classroom quality scores. Five measures of classroom quality were used to examine the global quality of the classroom environment; diversity and nonbias in the physical environment, materials, activities, and interactions; teacher involvement; responsiveness of teacher-child interactions; and the child-centeredness and organization of the classroom. Significant improvement was found after training across these domains. Improvements in classroom environment were found for both developmentally appropriate activities and appropriate caregiving. Teachers were more sensitive and responsive in their interactions with children following training. In addition, following training, classroom environments were more multicultural; teacher-child interactions were less biased; and classrooms were involved in more small group activities, child choice, and play-like atmospheres.

The results indicate that the intensive participatory model of training provided by this Head Start Teaching Center is effective in improving the quality of teaching practices in a wide variety of domains. This conclusion is further supported by the finding that there was no difference in improvement based on the particular training module that was selected. Further, in focus groups, the participants acknowledged the importance of such in-depth training for quality enhancement. These results have implications for the design of teacher training programs and quality enhancement efforts.

Reference:

Sameroff, A. J. (1983). Developmental systems: Contexts and evolution. In W. Kessen (Ed.), *Handbook of child psychology: Vol 2. History, theory, and methods* (pp. 237-294). New York: John Wiley & Sons.

■ Philadelphia Head Start Teaching Center (PHSTC): A Collaborative Training Model to Enhance Quality Services for Urban Head Start Programs

John Fantuzzo, Stephanie Childs, Kathleen Coyle Coolahan, Anise Dickerson-Waters

The purpose of this presentation is to foster discussion of issues related to enhancing quality of services in large urban Head Start programs. This will be accomplished by sharing how salient issues of an urban program shaped a model of quality enhancement and how the evaluation process raised program development issues by identifying wanted and unwanted outcomes.

A core assumption of PHSTC's training model is that a strong and vibrant Head Start community serves as the basis for the development of quality Head Start practices. The prevalence and intensity of social problems in urban centers have significantly damaged community organization and vital social networks. Given the impact of these harsh urban realities on community, PHSTC established community building and collaborative learning as its primary missions and developed the Collaborative Training (CT) model with three distinguishing features: conjoint teacher-parent training, hands-on exemplar-based training, and field-based training.

Two successive training curricula based on this model were tested in two large-scale evaluations. The first curriculum included: (a) teacher and parent classroom representatives participating in training together at the PHSTC, (b) teacher exemplars providing demonstration and instruction in developmentally appropriate adult-child classroom interactions, and (c) collaboration activities designed for teachers and parents to carry out in their classrooms. The evaluation of this curriculum revealed that teachers and parents in CT reported higher levels of active involvement and satisfaction with the training than did the workshop training (WT) group. Moreover, CT was associated with higher levels of positive teacher-child classroom initiations compared to observed levels in WT classrooms. However, both groups of parents evidenced the same low levels of adult-child classroom interactions and reported a relatively minor role in classroom instructional activities. The findings suggested that parental activity did not translate into dynamic parental involvement.

The revised CT curriculum added two components to enhance quality. First, a role for parent exemplars was included, and second, both parent and teacher exemplars demonstrated practice not only at the training center but also in the trainees' classroom environment. The results of the second evaluation replicated and extended findings from the first by indicating that CT had a greater positive impact on adult-adult and adult-child classroom interactions than WT. Overall, CT teachers and parents made more positive and nondirect initiations to parent volunteers than WT teachers. Additionally, they showed more positive interactions with children, including praise, supportive physical gestures, and instruction. Like the teachers, CT parents demonstrated greater levels of positive classroom interactions with children (instruction, praise, responsiveness, and supportive physical gestures and verbal exchanges) than WT parents. These findings support the collaborative training model as a means of raising the levels of developmentally appropriate adult-adult and adult-child classroom interactions.

■ Residential Training: A Template for Applied Learning Within the Head Start Context

Michele A. Strobridge

This presentation provides a description of an innovative staff development program implemented by 1 of the 14 grantees of a national 5-year demonstration initiative funded by the Head Start Bureau. This Teaching Center implemented the Mentoring and Training Toward Excellence (MATE) model, which was designed to provide experiential training in three Head Start functional areas—Early Childhood Development and Health Services, Family and Community Partnerships, and Program Design and Management.

The MATE approach was based on adult learning principles including: (a) desire for immediate application of the learning experiences, (b) knowledge of what is needed or desired to learn, (c) participation in the learning situation with many past experiences to draw upon to facilitate learning, and (d) "students" come to the learning situation ready to learn. During MATE, trainees engaged in 30 hours of interactive experiential learning activities in a format that replicated the teaching hospital model, in which after a theoretical presentation, interns are able to apply the knowledge they just acquired through hands-on activities. The interactive, ongoing learning process created by the Teaching Center can be represented by a figure 8-type loop.

Special characteristics of the MATE approach were: (a) small group sizes (10), (b) residency for 4 days, (c) daily learning group meetings, (d) guest lectures, (e) the keeping of journals with mentor feedback, (f) observation and participation in classrooms, home visits, and parent activities, (g) activity planning time, and (h) time for reading current articles. In addition, a comfortable learning environment was fostered by providing continental breakfast and lunch and having a facilitator support mentors by taking care of daily tasks, such as obtaining copies of articles when needed and attending to detail.

At the end of each day, Teaching Center staff met to debrief. This component created a mechanism for evaluation and the immediate opportunity for content or activity adjustment, if necessary. At the end of the week, participants identified goals they would implement before the 3-month follow-up meeting. This feature created the opportunity to apply newly acquired skills within the participants' actual work environment over a period of time and then to evaluate the outcome. New information was shared during the follow-up, and certificates of participation were presented.

As a result of being part of the national training and technical assistance network, a sense of pride swelled within the ranks, and there was evidence of work being completed with more care. This unspoken effort was recognized by Teaching Center staff through verbal praise, written thank you's, more opportunities to attend training for current information, and acquisition of Teaching Center mementos, such as coffee mugs and book bags.

The presentation will include information about outcomes from participating programs, including systemic changes that occurred as a result of the Teaching Center Experience. A format suggesting components for replication will be included.

ACYF Research, Demonstration, and Evaluation Branch

Quality is the Key to Effectiveness: The Head Start Quality Research Consortium

CO-CHAIRS: Marita R. Hopmann, Richard G. Lambert
PRESENTERS: Ellen S. Peisner-Feinberg, Martha S. Abbott-Shim, Lawrence J. Schweinhart, Martha Bronson

This symposium examines the complex relationships between program and classroom quality and outcomes as manifested in Head Start. As Head Start continues to expand its programs and the number of children served, the importance of quality in center-based care has become a central issue for research. The Head Start Quality Research Consortium (HSQRC) represents an ongoing partnership between the academic community and Head Start grantees. The HSQRC integrates the Head Start Bureau, the national multiple cohort Family and Child Experiences Survey (FACES) currently being studied, and four federally funded local research centers. The Consortium conducts research on program quality, development and validation of measures that assess quality, creation of ongoing databases and data analytic strategies, and information dissemination among researchers and practitioners. The Consortium also investigates the linkages among program practices and observable child and family outcomes.

The four local research centers are the presenters. The North Carolina Research Center on Head Start Quality presents findings on investigations of several measures of quality, including measures of the environment, teacher involvement, teacher-child interactions, and diversity. The Research Center on Head Start Quality at George State University explores the relationship between teacher beliefs and practices and classroom quality as well as the influence of teacher and teacher aide agreements regarding beliefs and practices. The High/Scope Educational Research Foundation presents findings related to the ability of teacher training and education to predict classroom quality in Head Start, public preschool, and nonprofit child care settings. The New England Quality Research Center for Head Start compares changes in observed social and mastery skills in Head Start children and the children's gender, age, first language, and classroom quality.

■ How Staffing and Staff Development Contribute to Head Start Program Quality and Effectiveness

Lawrence J. Schweinhart, Ann S. Epstein, Virginia Okoloko, Sherri L. Oden, Judy E. Florian

Secondary analysis of High/Scope's Training for Quality study (Epstein, 1993), conducted under the aegis of High/Scope's Head Start Quality Research Center, reveals new information about the influence of staffing and staff development on Head Start program quality.

Training of trainers projects have been one of the High/Scope Educational Research

Foundation's major training vehicles. In the Training for Quality studies, we surveyed consultants and trainers, interviewed and observed teachers in 366 High/Scope and non-High/Scope early childhood classrooms, and assessed the development of 200 children in High/Scope and non-High/Scope classrooms. The study showed that the Training of Trainers projects worked. They made trainers better trainers and teachers better teachers, and these teachers contributed more to the development of the children in their classrooms.

Over and above teachers' schooling and teaching experience, high-quality in-service training was a significant predictor of program quality. However, in-service training improved program quality only if it had certain components.

Findings for staffing and staff development varied across Head Start, public school preschools, and private, nonprofit child care centers. While nonprofit centers had the largest percentage of head teachers with bachelors' degrees (87%) followed by public school preschools (66%) then Head Start (50%), Head Start teachers had the largest percentage of head teachers with an early childhood degree or credential (88%). This is testimony to the success of the Child Development Associate credential as a vehicle for bringing early childhood training to Head Start teachers. Head Start and public school preschool teachers averaged 8–9 years of employment at their current agency as compared to only 4 years for head teachers in nonprofit agencies.

The overall picture emerging from this study emphasizes the importance of staffing issues in implementing high-quality, early education programs. In extending other studies (Cost, Quality, and Child Outcomes Study Team, 1995; Ruopp, Travers, Glantz, Coelen, & Smith, 1979; Whitebook, Howes, & Phillips, 1989) on the importance of general schooling versus specialized early childhood training, it was noteworthy that teaching staff in public school and nonprofit settings had more schooling, but more staff in Head Start had early childhood degrees or credentials. Head Start and public school teachers reported significantly more years of experience and employment at their agency than those in nonprofit settings (8–9 years vs. 4 years).

Perhaps most intriguing were the findings on effective in-service training practices. The training methods most positively associated with good program quality included curriculum-centered training, hands-on learning experiences, classroom observation and feedback to teachers, and continuity and follow-up by a consistent trainer. Unfortunately, in Head Start and other early childhood programs, training was all too often conducted using an *"expert-of-the-month"* model. This method is a series of unrelated experts lecturing staff on disconnected topics without any opportunity for follow-up assistance as teachers attempted to implement what they had learned. However, in-service training, done well, has enormous potential to contribute to the quality not only of Head Start programs, but also of all early childhood programs.

References

Cost, Quality, and Child Outcomes Study Team. (1995). *Cost, quality, and child outcomes in child care centers.* Denver: University of Colorado.

Epstein, A. S. (1993). *Training for quality: Improving early childhood programs through systematic in-service training.* Ypsilanti, MI: High/Scope Press.

Ruopp, R., Travers, J., Glantz, F., Coelen, C., & Smith, A. (1979). *Children at the center.* Cambridge, MA: Abt Associates.

Whitebook, M., Howes, C., & Phillips, D. (1989). *Who cares? Child care teachers and the quality of care in America.* Oakland, CA: Child Care Employee Project.

■ Fall-To-Spring Changes in the Social and Mastery Skills of Head Start Children

Martha B. Bronson, Anne L. Fetter

This investigation examines fall-to-spring changes in observed social and mastery skills and use of time in a sample of 122 Head Start children from 14 classrooms in six Massachusetts communities. Differences related to gender, age (3- vs. 4-year-olds), and child's first language (English vs. Spanish) were presented. Correlations between the observation variables and other measures are also shown.

The following table shows the demographic profile of the Head Start sample from the Fall–Spring 1996–97 data collection.

CHARACTERISTICS	SAMPLE	TOTAL AGE 3 (N=122)	AGE 4	GIRLS	BOYS
Language					
English	N=65	N=20	N=45	N=27	N=40
Spanish	N=57	N=24	N=33	N=31	N=24
Gender					
Girls	N=58	N=24	N=34	—	—
Boys	N=64	N=21	N=43	—	—
Age					
Three	N=44	—	—	—	—
Four	N=78	—	—	—	—

The Bronson Social and Tasks Skill Profile-Teacher Version (BSTSP-T; Bronson, 1996) was used to record classroom behaviors. The BSTSP-T is an observation instrument that uses structured categories and trained observers. Classroom behaviors are recorded in three areas: (a) use of time, (b) social interaction with peers, and (c) engagement in tasks with a goal. Observers trained to high (90% agreement) levels of reliability on all variables record the frequency and duration of classroom behaviors in 15-second intervals for six 5-minute periods. Using a modified time-sampling technique, three of the intervals begin when the target child becomes involved in a task with a goal (e.g., a puzzle, lotto game, matching activity, construction task) in which there is some opportunity to perform the task independently. The other intervals begin when the target child is involved in a social interaction with a peer. Individual behavior variables are summed over all six observations and reported as rate or proportion scores.

Findings were presented (see Tables 1 through 4).

The Head Start children observed in this study improved significantly from fall to spring on almost all behavior variables examined. There were some differences related to age, gender, and the first language spoken by children (English or Spanish) in both the fall and spring. These differences showed some advantages for older children, girls, and native English speakers. A number of the behavior variables showed low to moderate correlations with other child measures and a measure of classroom quality administered in the spring.

Table 1.
Fall-to-Spring Changes[1] on the BSTSP-T Variables in Fall 1996 and Spring 1997 Head Start Observations

OBSERVATION VARIABLES	FALL N=122			SPRING N=122			DIFFERENCE	
	X	SD	Range	X	SD	Range	t	Significance
TIME VARIABLES								
Proportion observation time in social interaction with peers	.34	.16	.00–.55	.39	.15	.00–.65	3.21	.002
Proportion social time in organized interaction with peers	.17	.20	.00–.95	.19	.23	.00–.91	.99	NS
Proportion observation time in task with a goal	.28	.14	.00–.44	.33	.15	.06–.74	2.84	.005
Proportion time distracted in task with a goal	.06	.10	.00–.62	.03	.04	.00–.20	-2.79	.006
Proportion observation time spent watching/waiting/in transition	.11	.08	.00–.37	.09	.07	.00–.32	-1.98	.050
Proportion observation time uninvolved	.03	.05	.00–.19	.02	.03	.00–.25	-2.76	.007
SOCIAL VARIABLES								
Rate attempts to organize interaction with peers	.30	.36	.00–1.33	.60	.58	.00–2.76	4.55	.000
Rate accommodates to others in interaction with peers	.34	.30	.00–2.86	.38	.31	.00–1.40	.79	NS
Rate all attempts to influence peers	3.46	1.53	.59–10.00	3.87	1.37	1.05–8.39	2.20	.030
Proportion successful attempts to influence peers	.65	.17	.23–1.00	.70	.16	.00–1.00	2.45	.016
Proportion verbal attempts to influence peers	.75	.19	.08–1.00	.80	.17	.00–1.00	2.92	.004
Rate resists rules or teacher	.05	.10	.00–.50	.06	.14	.00–.93	.43	NS
TASK WITH A GOAL VARIABLES								
Rate organizes task	.14	.22	.00–1.20	.15	.18	.00–1.12	.23	NS
Rate follows plan in task	.81	.86	.00–4.75	1.60	.89	.00–4.17	7.03	.000
Rate monitors task	2.08	1.22	.00–7.19	2.39	1.08	.48–8.67	2.09	.039
Proportion tasks completed successfully	.70	.31	.00–1.00	.81	.24	.00–1.00	3.46	.001

[1] Fall-to-spring differences were analyzed with t tests (fall vs. spring scores).

Table 2. Significant Differences[1] Fall to Spring on BSTSP-T Scored Variables of Different Subgroups Observed in 1996–97 Head Start Observations

OBSERVATION VARIABLES	TOTAL GROUP N=122	CHILDREN AGE 3 N=44	CHILDREN AGE 4 N=78	MALE CHILDREN N=64	FEMALE CHILDREN N=58	ENGLISH SPEAKERS N=65	SPANISH SPEAKERS N=57
TIME VARIABLES							
Proportion observation time in social interaction with peers	** (increased)	** (increased)	(*) (increased)	*** (increased)	—	—	** (increased)
Proportion social time in organized interaction with peers	—	—	—	—	—	—	—
Proportion observation time in task with a goal	** (increased	—	* (increased)	—	** (increased)	—	** (increased)
Proportion time distracted in task with a goal	** (decreased)	* (decreased)	(*) (decreased)	—	* (decreased)	(*) (decreased)	* (decreased)
Proportion observation time spent watching/waiting/in transition	* (decreased)	* (decreased)	—	—	* (decreased)	— (decreased)	* (decreased)
Proportion observation time uninvolved	** (decreased)	(*) (decreased)	* (decreased)	* (decreased)	* (decreased)	* (decreased)	(*) (decreased)
SOCIAL VARIABLES							
Rate attempts to organize interaction with peers	*** (increased)	* (increased)	*** (increased)	** (increased)	** (increased)	*** (increased)	** (increased)
Rate accommodates to others in interaction with peers	—	—	(*) (increased)	—	—	—	—
Rate all attempts to influence peers	* (increased)	—	*** (increased)	—	** (increased)	** (increased)	—
Proportion successful attempts to influence peers	* (increased)	—	** (increased)	* (increased)	—	* (increased)	—
Proportion verbal attempts to influence peers	** (increased)	* (increased)	(*) (increased)	* (increased)	* (increased)	—	*** (increased)
Rate resists rules or teacher	—	—	—	—	—	—	—
TASK WITH A GOAL VARIABLES							
Rate organizes task	—	—	—	—	—	—	—
Rate follows plan in task	*** (increased)	** (increased)	*** (increased)	*** (increased)	*** (increased)	*** (increased)	*** (increased)
Rate monitors task	* (increased)	* (increased)	—	—	* (increased)	(*) (increased)	—
Proportion tasks completed successfully	*** (increased)	*** (increased)	(*) (increased)	—	*** (increased)	* (increased)	** (increased)

[1] Fall-to-spring differences were analyzed with t tests (fall vs. spring scores).
— = no significant difference (*) p=.10 * p=<.05 ** p=<.01 ***p=<.001

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Table 3
Summary of Significant Differences[1] Associated with Age, Gender, and Child Language in BSTSP-T Scored Behavior Variables in Fall 1996 and Spring 1997 Head Start Observations

OBSERVATION VARIABLES	SIGNIFICANT DIFFERENCES BY AGE[2]		SIGNIFICANT DIFFERENCES BY GENDER[2]		SIGNIFICANT DIFFERENCES BY LANGUAGE[2]	
TIME VARIABLES	**FALL**	**SPRING**	**FALL**	**SPRING**	**FALL**	**SPRING**
Proportion observation time in social interaction with peers	.000 (Age 4)	.001 (Age 4)	NS	.044 (Boys)	.008 (English)	NS
Proportion social time in organized interaction with peers	.001 (Age 4)	.001 (Age 4)	.043 (Girls)	NS	NS	NS
Proportion observation time in task with a goal	NS	NS	NS	.012 (Girls)	NS	.013 (Spanish)
Proportion time distracted in task with a goal	NS	NS	NS	NS	NS	NS
Proportion observation time spent watching/waiting/in transition	.037 (Age 3)	NS	.037 (Girls)	NS	NS	NS
Proportion observation time uninvolved	NS	NS	NS	NS	NS	NS
SOCIAL VARIABLES						
Rate attempts to organize interaction with peers	NS	(.100) (Age 4)	NS	NS	NS	NS
Rate accommodates to others in interaction with peers	NS	NS	NS	NS	NS	NS
Rate all attempts to influence peers	NS	NS	(.056) (Boys)	NS	NS	.046 (English)
Proportion successful attempts to influence peers	NS	.011 (Age 4)	NS	NS	NS	NS
Proportion verbal attempts to influence peers	.011 (Age 4)	NS	NS	NS	.012 (English)	NS
Rate resists rules or teacher	NS	NS	.006 (Boys)	.016 (Boys)	NS	NS
TASK WITH A GOAL VARIABLES						
Rate organizes task	NS	NS	NS	NS	NS	NS
Rate follows plan in task	NS	(.054) (Age 4)	NS	NS	NS	NS
Rate monitors task	NS	NS	NS	NS	NS	NS
Proportion tasks completed successfully	.048 (Age 4)	NS	NS	.017 (Girls)	NS	NS

[1] Significance levels based on F values in ANOVA procedures.
[2] Group scoring significantly higher listed in parentheses.

Table 4. Correlations Between Bronson Profile (BSTSP) Variables and Language Measures, the SSRS, the COR, and two Subscales of the Classroom Profile in Spring 1997 NEQRC Head Start Data Collection

SAMPLE OBSERVATION VARIABLES	PPVT TOTAL SAMPLE TEST IN ENGLISH N=73	TVIP SPANISH LANGUAGE TEST IN SPANISH N=14	TEACHER EVAL. OF LANGUAGE & LITERATURE N=80	EMERGENT LITERACY TOTAL SCORE N=59	BOOK CONCEPT TOTAL SCORE N=58	SSRS SOCIAL BEHAVIOR SUBSCORE N=79	COR SOCIAL BEHAVIOR SUBSCORE N=80	COR RATINGS TOTAL SCORE N=80	CLASS PROFILE ENVT SUBSCALE SCORE N=14[1]	CLASS PROFILE SCHEDT SUBSCALE SCORE N=14
TIME VARIABLES										
Proportion observation time in social interaction with peers	.34**	(.47)		.29*			(.19)	.28**	.30**	.25**
Proportion social time in organized interaction with peers	.24*	.63*		.27*					.25*8	.40**
Proportion observation time in task with a goal	-.32**									.38***
Proportion time distracted in task with a goal										
Proportion observation time spent watching/waiting/in transition					-.26*			(-.19)		
Proportion observation time uninvolved										
SOCIAL VARIABLES										
Rate attempts to organize interaction with peers	.28**	.59*							.22*	.32*
Rate accommodates to others in interaction with peers			.25*	.44***	.33**	.30**	.26*			
Rate all attempts to influence peers	.29**							.22*		.24*
Proportion successful attempts to influence peers				.31**	.37**				.31***	
Proportion verbal attempts to influence peers		.52*	.29**	(.21)		.33**	.30**	.34**		
Rate resists rules or teacher	-.31**	(-.48)	-.39***			-.45***	-.33**	-.35**		
TASK WITH A GOAL VARIABLES										
Rate organizes task										
Rate follows plan in task		(.30)	.28**	.39**	(.21)		.32**	.39***		
Rate monitors task	.25**						(.20)			
Proportion tasks completed successfully			.24*	.27*	.31*	.29**	.29**	.31**		

[1] Classroom average scores in each of the 14 classrooms were compared to the Classroom Profile (Abbott-Shim & Sibley, 1996), a measure of classroom quality.

* p<.05 **p<.01 ***p<.001 ( ) p>.05 & <.11

■ Patterns of Quality in Head Start: From Diversity to Development Appropriateness

Ellen S. Peisner-Feinberg, Donna M. Bryant

Summary not available at time of publication.

■ The Relationship Between Teacher Beliefs and Practices and Head Start Classroom Quality

Frances A. McCarty, Martha S. Abbott-Shim, Richard G. Lambert

Summary not available at time of publication.

Ensuring Quality in Head Start: Early Data From the Head Start Family and Child Experiences Survey (FACES)

CO-CHAIRS: Louisa B. Tarullo, Henry Doan
DISCUSSANT: Richard Gonzales
PRESENTERS: Ruth Hubbell McKey, David B. Connell, Gary Resnick, Nicholas Zill, Robert W. O'Brien, Mary Ann D'Elio

The Head Start Family and Child Experiences Survey (FACES) is a longitudinal study of the quality and effectiveness of Head Start based on a nationally representative sample of programs, children, and families. FACES is the first opportunity to utilize the Head Start Program Performance Measures in order to assess program quality. In addition it represents an opportunity to recommend options for improving program performance along several dimensions. In particular, FACES measures the Head Start classroom environment, children's cognitive and social development, the relationship between quality and children's development, and effects on parental behavior and progress toward family goals. Comprehensive information is being collected periodically from Head Start programs, children, and families from the time each child enrolls in Head Start to the end of that child's kindergarten year. Researchers hope that data will link the characteristics of the Head Start program to parent and child outcomes over the study period.

Ruth Hubbell McKey from Ellsworth Associates discussed the development and application of the Head Start Program Performance Measures, including their relation to FACES and other Head Start data sources. David Connell and Janet Swartz from Abt Associates outlined data collection and sampling methodology. Nicholas Zill and Gary Resnick from Westat provided a general overview of the study's measures of classroom quality and child outcomes. They also presented findings from the spring 1997 FACES field test regarding the quality of Head Start classroom environments. Robert O'Brien and Mary Ann D'Elio from The CDM Group presented findings from the spring 1997 FACES field test on family characteristics.

■ The Head Start Program Performance Measures Initiative

Ruth Hubbell McKey

The Head Start Program Performance Measures were developed in response to recommendations of the Advisory Committee on Head Start Quality and Expansion and the Government Performance and Results Act that required all federal agencies to move towards developing an outcome-oriented accountability system that examines the quality of Head Start programs and the effects of Head Start on children and families. In 1995, a consensus-building process was used to develop an initial set of measures through the use of focus groups of Head Start program administrators, staff, parents, researchers, and early childhood experts. The process continued with the development of a conceptual framework for the measures in a pyramid form that builds process to outcome measures toward the ultimate goal of Head Start, which is to promote the social competence of children. The pyramid contains five objectives for Head Start: (a) enhancing children's healthy growth and development, (b) strengthening families as the primary nurturers of their children, (c) providing children with educational, health, and nutritional services, (d) linking children and families to needed community services, and (e) ensuring well-managed programs that involve parents in decision-making.

There are a total of 24 program performance measures. The measures themselves are presented in a matrix that lists the objective, measure, indicators, data sources, and data for each measure. There are four major sources of data for the measures. The Head Start Program Information Report (PIR) provides self-reported program level data for all 2,000 Head Start programs on such items as services provided, staff qualifications, and child characteristics. The Head Start Monitoring System (HSMTS)—currently under revision— provides data gathered by monitoring teams on one third of the programs annually. The Family and Child Experiences Survey (FACES) collects child and family outcome data and program quality data on a national random sample of 3,200 children in 40 programs. Finally, the ACYF Regional Offices provide information on management measures. The measures will be used to provide feedback to programs, target resources, improve training and technical assistance, and advise long-range planning and policy development in order to improve quality and effectiveness.

The measures are part of the overall Head Start quality initiative to improve Head Start programs. The other components of the initiative are the revision of the Head Start Program Performance Standards, revision of the monitoring system, enhancement of the grant-making process, and revision of the training and technical assistance system. All of these efforts interrelate and build on each other to improve the quality and performance of Head Start programs and their effects on children and families. The Head Start Program Performance Measures Second Progress Report presenting the measures and data on them from these data sources and the first FACES fieldtest in spring of 1997 is available on the ACYF Research, Demonstration and Evaluation and Head Start Bureau websites at http://www.acf.dhhs.gov/programs/rde or http://www.acf.dhhs.gov/programs/hsb.

■ The Design of the Family and Child Experiences Survey (FACES)

David B. Connell

The Head Start Family and Child Experiences Survey (FACES) involves a longitudinal study of over 3,000 families in Head Start programs distributed nationally. The fieldtest for FACES was completed in Spring, 1997, on a nationally representative sample of 2,400 families. The primary sample for the study was selected in Fall, 1997, and included approximately 3,200 families in 182 centers across 40 Head Start programs. Families will be tracked until all participating children complete kindergarten. Complete information, including parent and staff interviews, classroom observations, and child assessments, will be collected in Spring, 1998, Spring, 1999, and Spring, 2000. Data collection for a separate substudy of 120 families who have been contacted monthly will be completed in December, 1998.

■ Is Head Start Providing High-Quality Educational Services?

Gary Resnick, Nicholas Zill

One of Head Start's key performance objectives is to provide children with high-quality, developmentally appropriate educational services. The Head Start Family and Child Experiences Survey (FACES) is a longitudinal study of a nationally representative sample of Head Start children. The study has been designed to assess the quality of educational services through direct observation of Head Start classrooms in operation and to correlate program quality with children's social and cognitive development. This presentation focused on findings with regard

to quality, from the first cohort of the FACES conducted during the spring of 1997 using a national sample of Head Start classrooms.

FACES assesses the three primary domains of program quality: structure, processes, and teacher qualifications. Process measures of quality used reliable, well-known measures, including the Early Childhood Environment Rating Scales (ECERS), the Scheduling and Learning Environment scales from the Assessment Profile, and the Arnett Scale of Caregiver Behavior. Specially trained classroom observers spent an entire "Head Start day" in each classroom. Structural measures consisted of classroom size and adult-child ratio. Questionnaires completed by the teachers provided information about the teacher's qualifications and training.

Classroom data were collected in all 40 programs in the sample and 156 out of 157 possible centers. A total of 403 classrooms were observed out of a possible 414 for a completion rate of 97%. Agreement between two independent observers in a sample of classrooms averaged 91% for the Assessment Profile and 86% across all ECERS scales.

A major finding of the spring 1997 FACES was that the overall average ECERS score for the 403 classrooms in the national sample was 4.9 (with a standard deviation of 0.6). Seventeen percent of the Head Start classrooms were given average ratings of 6 or higher (on a 7-point scale) while only 1.5% of classrooms had an average score of 3. No classrooms had an average score lower than 3. A comparison of these findings with previous studies of center-based preschools reveals that average quality in Head Start classrooms is higher than that found in most center-based child care and preschool programs and that Head Start programs do not have the same "bottom" to the distribution found in these other programs.

Structural aspects of program quality further supported the conclusion that the quality of many Head Start classrooms is good and higher than other center-based preschool programs. The class size averaged 13.6 children which meets or exceeds the monitoring standards. The average child to adult ratio for the FACES Head Start classrooms was 5.6 children per adult, which is far better than the NAEYC accreditation standard and exceeds the Head Start Program Performance Standards.

Finally, we presented data on the teaching qualifications of Head Start lead teachers and on a structural model showing the relationship between teacher qualifications and structural and process measures of classroom quality. The results point to the importance of the teacher, program, and center characteristics in affecting classroom quality in Head Start.

■ Ensuring Quality in Head Start: Early Data from the Head Start Family and Child Experiences Survey (FACES)

A Report on Characteristics of the Families Being Served by Head Start

Robert W. O'Brien, Mary Ann D'Elio

The findings presented here are from the FACES Spring 1997 fieldtest of in-depth interviews with 2,390 primary caregivers. Respondents were primarily mothers (88%; 94% were parents) with a mean age of 31. While one fifth of the respondents were not born in the US (almost one quarter were interviewed in a language other than English), 97% of the children were. Forty-five percent of the primary caregivers were married, and 35% were single or never married. Households, with a mean of 4.7 people (including parents, children, and other household members), were the homes of 47% of the fathers and 93% of the mothers. Both parents were present in 45% of the households. About 71% of the primary caregivers had a high school diploma or better. In 21% of the families, both parents were employed, and in 30% neither parent was employed. At least one household member was employed in 79% of the households. The reported use of public assistance included welfare (32%), medical assistance (59%), Food

Stamps (51%), and WIC (48%). No income support or assistance was reported for 16% of the households.

Findings highlighted the use and potential need for family services. For example, 18% of the children were reported to have one or more disabilities, most often speech or language problems. Child care was needed for 42% of the children prior to enrollment and for 25% of enrolled children before or after the Head Start day. Many respondents reported they had been exposed to domestic and/or neighborhood violence (30% heard or saw violent crime in the neighborhood, 5% were victims in their neighborhood, and 7% were victims in their homes).

Reports of family activities with the target child during the past week and over the previous month indicated that mothers were by far the family member most often engaged in each of 22 activities with the child, followed by siblings and then fathers. Activities with nonhousehold family members were relatively infrequent. Reports by the respondents of social support received for raising the child over the previous 3-6 months showed that the Head Start staff were helpful for almost 95% of the families and very helpful for about 70% of the families. The percentage of respondents rating relatives and friends as helpful was 86% and 70%, respectively.

Overall, parents were very satisfied with their experiences in Head Start. On each of eight items, over 80% of respondents were very satisfied with Head Start and over 90% were at least satisfied. Parent participation in Head Start activities was not as high as might be expected, given the number of required activities, such as home visits or parent-teacher meetings. Nine activities were each named by at least 50% of the parents. A parent participation summary score was positively related to parent education, having a primary caregiver employed, and the number of parents in the household. Barriers to participation in Head Start were most likely parent work schedules (49%) and a need for additional child care (35%).

Evaluation of the Head Start Transition Demonstration: Perspectives From Local and National

CHAIR: Mary Bruce Webb

This poster symposium presented selected findings from several of the 31 local research sites and from the national evaluation of the Head Start/Public School Early Childhood Transition Demonstration program evaluation. The Transition Demonstration program was authorized by Congress to provide a program of continuous and coordinated services to children as they leave Head Start and progress through the early grades of school. The goal of the demonstration is to identify those services that are most effective in helping children and families sustain early gains made in Head Start programs. In 1991, 31 local sites received demonstration grants to construct and evaluate transition programs based on their individual strengths, needs, resources, and philosophies. The Civitan International Research Center at the University of Alabama at Birmingham was selected to coordinate the national evaluation of the demonstration program.

Several local researchers, including representatives from North Carolina, Maryland, Massachusetts, South Dakota, and Alabama, presented posters on their site-specific findings. Local research topics include the meaning of participation in Head Start transition programs, transition activities and their effectiveness, and the influence of Head Start parent involvement practices on children's academic competence. National researchers presented qualitative research from three demonstration sites and discussed variations in local implementation of transition programs. A poster presenting the application of qualitative methods in early intervention research was also included.

■ What Is "Participation" in North Carolina's Head Start Transition Demonstration?

Donna M. Bryant, Frances A. Campbell, Karen B. Taylor, Margaret R. Burchinal

In the North Carolina Transition Demonstration Project, early childhood educators and social workers provided intervention services to Head Start graduates from kindergarten through third grade. The intervention group also included non-Head Start children from poor families, for a total of 100 intervention children. Both intervention groups were compared to 123 similar children (both Head Start and non-Head Start) who attended schools that had been randomly assigned to a control condition. Intervention consisted of home visits with parent and/or child for educational enrichment (n= 790), individual educational activities (usually at school) directly with the child (n=1,258), group sessions with children for educational enrichment (n=573), and contacts with teachers and children in classrooms (n=2524), with families for family support (noneducationally related; n=12,737), and with other professionals in the schools and community (n=6,557). All intervention records were coded and summarized annually.

The level of "treatment" was expected to vary widely because families needed or wanted to participate at different levels. Information was presented on how we documented child and family participation and investigated whether different participation indices differ in their utility for predicting child outcomes. Children were assessed and families interviewed in the fall of kindergarten and in the spring of each year, kindergarten through grade 3. For these analyses, the two reading subtests of the Woodcock-Johnson Psycho-Educational Battery-Revised (1989)

were used. A risk indicator for each family was also created to account for some of the variability in family types and stability: 42% of families were low risk with no or one indicator, and 41% of families were medium risk with two to three indicators.

"Participation" was defined in five different ways: (a) Simple participation: whether the child was assigned to the intervention group; (b) Number of home visits, grouped by terciles; (c) Number of group activities with child, grouped by terciles; (d) Number of individual educational activities with child, grouped by terciles; and (e) Total of (b), (c), and (d): home visits + group activities + individual activities, grouped by terciles. Different prediction models ranging from the simplest to the most detailed were used to try to predict educational outcomes.

In summary, no effects of the Transition treatment on children's reading abilities over time were found, whether looking at treatment simply (as a member of the treatment group) or in a more complex way (by quantifying the many different types of educational experiences received by the child/family). It is thus difficult to conclude that a particular way of documenting participation is better than another.

Within this low-income sample, the risk status of the children's families seems to be a significant factor in their school achievement, with children from families with more risk factors scoring lower on reading. The local school system tries to provide extensive help to any child who needs additional resources, so the children in the control (non-Transition) schools received a number of school-provided interventions and services over their first 4 years of school. This may be why that the Transition intervention, as it was delivered at this site, was found not to have a significant effect on children's school success.

■ Transition Activities and Their Effectiveness

Carol Seefeldt, Alice R. Galper, Tina M. Younoszai

It has long been accepted that Head Start is beneficial for children and their families. Children make social and academic gains while in Head Start and their families achieve greater autonomy. Too often, however, these benefits are not lasting. By the third grade, Head Start children's gains have dissipated, and without continuing support services, the social and economic gains made by their families have also been depleted. To counteract this loss, the Head Start-Public School Transition Demonstration was conceived. The purpose of the Transition Demonstration was to provide Head Start children and their families with a comprehensive Head Start-like program of health, parent involvement, social support, and implementation of developmentally appropriate classroom practices, as they made the transition from Head Start to kindergarten and through grade 3.

The presentation described the effects of specific activities and full participation in the Montgomery County Transition Demonstration, 1 of the 31 Transition Demonstrations implemented across the nation. The effects were assessed through family interviews, assessment of children, retroactive case studies, and in-depth case studies. The specific questions were: (a) Do participation in the specific activities of Family Nights Out and development of an Individual Transition Plan affect child or parent outcomes? (b) What are the characteristics of families who participated fully in the Demonstration and those who did not? and (c) Do in-depth case studies suggest program benefits?

The primary goal of the Montgomery County Demonstration was to empower parents to become equal partners with educators in their children's education. The Demonstration was largely implemented by Family Service Coordinators, licensed social workers, in each of the Demonstration schools. The Comparison schools did not have a Family Service Coordinator, but did have competing social, health, and parent involvement activities.

Two popular activities of the Transition Demonstration were Family Nights Out (FNO) and

the Individual Transition Plan (ITP). Family Nights Out involved parents, children, other family members, teachers, and the school principal in a monthly night out. Following dinner, a family therapist led a group discussion while the children played in another part of the school. The ITP involved parents and their children's current and future teachers at the end of their children's school year. Together the teachers and parents completed a plan for their children's transition from one grade placement to the next.

Former Head Start families in four Demonstration and four Comparison schools were interviewed and their children assessed beginning in the fall and spring of their children's kindergarten year. The interviews reported in this study were conducted in the spring of each year through the end of the children's third grade year and are only those interviews and assessments of families and children in the Demonstration schools. Questions assessing demographics, health, and level of parent involvement were asked and other questionnaires administered. Children were assessed using standardized tests of academic achievement, the Mathematics and Reading Subtests of the Woodcock-Johnson Tests of Achievement-Revised (WJ-R) and the Peabody Picture Vocabulary Test-Revised (PPVT). Children were also asked to respond to other questionnaires beginning in the fall of the kindergarten year and continuing through the spring of the third grade year.

Retroactive case studies on families in the Demonstration schools were conducted at the end of the children's third grade year to answer the third question, "Are there differences between families participating fully in the Demonstration and those who did not?" The Family Service Coordinators were asked to identify families' level of participation in the Demonstration. Using this report as well as previously collected questionnaire data addressing level of reported parent involvement, achievement of efficacy, and academic and receptive achievement of their children, families were grouped into high and low levels of participation/achievement. Four Demonstration families volunteered to participate in an in-depth case study. Of these four, three were available and agreed to be interviewed. A professor of human development conducted the case studies, asking each family the same set of questions designed to address families' perceptions of and involvement in the Demonstration.

Children in the Demonstration schools whose parents had participated in both the FNO and ITP (N=16) were found to have significantly higher achievement on the WJ-R Letter Word Subtest (M=38.75, SD=5.85) than children whose parents had not participated in both FNO and ITP (N=39, M=34.10, SD=8.11, F (1,54)=4.30, p <.05). Parents appeared to benefit as well. Those who reported participating in both FNO and ITP (N=10) made significantly higher increases in beliefs in their own self-efficacy from their children's kindergarten year through the end of grade 3 (M=.52, SD .86) than parents who had not (N=11, M=.31, SD=.96, F (1,20)=4.39, p <.05).

The Demonstration families who had participated in the Demonstration from kindergarten through grade 3 were grouped by level of participation in the program, level of reported parent involvement, achievement of efficacy, and academic and receptive achievement of their children. Of the 40 families participating in all 3 years of the program, 14 were identified as having high participation and achievement and 11 as having low participation and achievement. Ten of the 14 parents in the high group reported having been born in a country other than the U.S. Nine of the families were of Hispanic heritage, three African American, and two Asian. Seven of the families said there were two adults in their homes, five said three adults, and one reported one adult. Half of the families in the high group reported higher incomes at the end of the Demonstration than they reported at the beginning. Eight of the 14 reported having participated in the development of an ITP and 9 in FNO.

Eight of the 11 families in the low group were of African American heritage and three were Hispanic. Five reported having been born in a country outside of the U.S. Three reported two adults in the home, three said three adults were in the home, and in four homes there was only one adult. Four of the families said they had participated in developing an ITP and four at-

tended FNO. Higher incomes at the end of the Demonstration than the beginning were reported by 2 of the 11 families.

The families participating in the Case Studies indicated that the support of the Family Service Coordinators was most valuable. The families said they had received help in locating needed resources and services. One said, "When I needed emergency food and financial assistance, my Family Service Coordinator was right there." Another said, "The Family Service Coordinator is the heart of the Transition Demonstration."

Despite the small sample size and unequal group sizes, these findings suggest that specific activities of the Transition Demonstration in Montgomery County were effective. The findings hint at the potential of activities like FNO and the development of an ITP to affect families and children. With larger sample sizes and equal groups, the findings may have been stronger. Then too, the findings suggest the obvious. In order to benefit from programs, it is first necessary to participate in the programs.

■ Documenting Changes in Early Childhood Education: A Qualitative View of the National Head Start/Public School Early Childhood Transition Demonstration Project

Sharon M. Allen, Ray H. Thompson, Jane Drapeaux, Linda Spatig, Laurel Parrott, Katie F. Conrad, Amy Dillon, David S. Robinson

This presentation focused on the National Head Start/Public School Early Childhood Transition Demonstration Project (NTP), a federally funded longitudinal study. A range of perspectives was offered on the implementation process, including the vantage points of participants, researchers, policy analysts, and practitioners from three ethnically and culturally diverse geographic areas. The project, which was implemented in the fall of 1992, followed two cohorts of former Head Start children and their families from prekindergarten through the third grade.

The three sites generated qualitative data that describe and interpret the implementation process, program effects, and lessons learned as well as provide suggestions for future programs. Qualitative evaluation has gained in popularity since the late 1970s, especially because of increasing concerns about the weaknesses of largely quantitative systems-analytic approaches to program evaluation (LeCompte & Preissle, 1993). Multifaceted programs with varying degrees of implementation and benefits call out for methods that illustrate political and cultural contexts (Greene & McClintock, 1991).

Allen, Thompson, and Drapeaux, in presenting data from South Dakota, argued for the centrality of gender in the interpretation of data and used interpretive feminist inquiry to construct participants' gendered views of reality. They felt that, since gender is a basic organizing principle that profoundly shapes how people view the world (see Kramer, 1991; Lather, 1992; Madoo Lengermann & Niebrugge-Brantley, 1988; Saltzman Chafetz, 1988), it was important to interpret the data through the "lens of gender." Women represented the majority of the participants in the South Dakota study: 73 of the 75 parents, 83 of the 84 teachers, all 13 family service coordinators, and about half of the principals. While the female "voices" were varied in their perceptions of the project, they were primarily "singular" in their positive feelings toward the project. Women in their roles as parents felt "stretched to the limit" and were thankful for the assistance and encouragement received through the project. Women in their roles as family service coordinators were advocates for children and provided the communication link between homes, schools, and agencies. Women in their roles as teachers reflected on their teaching practices and incorporated more developmentally appropriate practices into their curriculum.

Spadig, Parrott, Conrad, and Dillon's presentation focused on their collaboration experiences

in the West Virginia site. Their data consisted of transcripts and notes from two, day-long team "retreats," frequent team meetings that were held throughout the 5-year study, and reflective memos written by individual team members. Like Liggett, Glesne, Johnston, Hasazi, and Scattman (1994), they found that teaming was expensive in terms of money, time, and energy. For example, they spent huge amounts of time in meetings hashing out the pros and cons of various alternatives in what were sometimes frustrating attempts to make group decisions about how to provide helpful, formative feedback to program implementators. The division of labor on the teams, with three people doing most of the data collection and one person doing most of the writing, was also difficult and required diligent efforts at communication and understanding among team members. The professional benefits of teaming far outweighed its difficulties and their collaboration resulted in a deeper and fuller understanding of the data.

Finally, Robinson presented a qualitative evaluation of NTP implementation at the state level in Rhode Island. Project REACH emphasized reaching families and involving them in their children's education. Robinson described definitions in use by school-based family support personnel, identified barriers, and described school-based family support efforts. The role of Family Service Coordinators (FSC) was described as well as their efforts within the public schools to make parent involvement more feasible for teachers and parents. Family Service Coordinators and teachers met weekly to assess the strengths and needs of individual children in classrooms. How to use this information so that teachers could modify classroom or learning strategies served as the impetus for professional development efforts in the last 2 years of the project. There were barriers emanating from within and outside the project to inhibit family involvement, however, which FSC had to overcome in order to be successful in their goals and objectives. These barriers were grouped into six types: (a) work climate factors, (b) role factors and boundaries, (c) school site factors, (d) teacher factors, (e) parent factors, and (f) child characteristics.

References

Greene, J. C., & McClintock, C. (1991). The evolution of evaluation methodology. *Theory Into Practice, 30*, 13–21.

Kramer, L. (1991). *The sociology of gender: A text-reader.* New York: St. Martin's.

Lather, P. (1992). Critical frames in educational research: Feminist and poststructural perspectives. *Theory Into Practice, 31*, 87–99.

LeCompte, M., & Preissle, J. (1993). *Ethnography and qualitative design in educational research* (2nd ed.). San Diego: Academic Press, Inc.

Liggett, A., Glesne, C., Johnston, A., Hasazi, S., & Schattman, R. (1994). Teaming in qualitative research: Lessons learned. *Qualitative Studies in Education, 7*(1).

Madoo Lengermann, P., & Niebrugge-Brantley, J. (1988). Contemporary feminist theory. In G. Ritzer (Ed.), *Sociological theory* (2nd ed., pp. 400-441). New York: Alfred A. Knopf.

Saltzman Chafetz, J. (1988). *Feminist sociology: An overview of contemporary theories.* Itasca, IL: F. E. Peacock.

■ Variations in Local Implementation of the Transition Demonstration: Perspectives From the National Evaluation

Martha Phillips, Craig Ramey, Sharon Ramey, K. Robin Gaines Lanzi

Summary not available at time of publication.

■ Head Start Transition Outcomes: Families and Children

Susan M. Hegland, Karen Colbert

Transition outcomes were studied for 105 Head Start children and families in the seven elementary schools of a small, midwestern city. Transition services were offered in two demonstration schools, both Chapter 1 schools; the remaining five schools served as comparison schools. Transition services included home visits, additional health and mental health services in schools, and summer school-based and community programs for children and families. The sample of children and families was predominantly White; 85% of the children remained in the study through third grade.

Head Start families whose children attended only transition demonstration schools in each grade from kindergarten through third grade (n = 24) did not differ from Head Start families whose children attended only comparison schools (n = 27) in any demographic characteristic, including family income, parent education, family structure, or family moves. Children in the two groups did not differ on kindergarten assessments of language (Dunn & Dunn, 1980), reading, or mathematics (Woodcock & Johnson, 1990). In order to assess the impact of transition services on parent involvement in children's learning, we used the work of Epstein (1992) to develop two indices of parent involvement. Parent involvement in school was assessed through a set of eight activities (e.g., participation in school conferences) that, according to 70% of parents from each school group, were available in both demonstration and comparison schools. Parent involvement in home learning was assessed by an index of 10 activities in which parents were engaged with their child nearly every day (e.g., playing together).

By the end of second grade, Head Start parents whose children had attended only demonstration schools reported higher levels of involvement in school activities, but not in home learning, than did Head Start parents whose children had attended only comparison schools. Head Start children who had attended only demonstration schools were evaluated by their third grade teachers as showing higher levels of social skills (Gresham & Elliott, 1990) than were Head Start children who had attended only comparison schools. In addition, children who had attended only demonstration schools showed higher levels of reading skill (Woodcock & Johnson, 1990) than did Head Start children who attended only comparison schools. However, there were no differences in the mathematics achievement of the two groups of children.

A third group of Head Start families whose children had attended both demonstration and comparison schools (n = 38) were a diverse group with an uneven pattern of outcomes, including considerable variance in their parental involvement scores. These families included both families whose circumstances greatly improved and families whose circumstances had worsened from kindergarten through third grade. As a group, they differed from the demonstration and comparison families in three areas: more family moves from kindergarten through third grade, more single parents, and more parents who spent time in jail. We interpreted the results as supporting the impact of transition services on family involvement in school and on the social and academic competence of Head Start children.

References

Dunn, L. M., & Dunn, L. M. (1981). *Peabody Picture Vocabulary Test-Revised: Manual for forms L and M.* Circle Pines, MN: American Guidance Service.

Epstein, J. L. (1992). *School and family partnerships.* Baltimore, MD: John Hopkins University.

Gresham, F. M., & Elliott, S. N. (1990). *Social Skills Rating System manual.* Circle Pines, MN: American Guidance Systems.

Woodcock, R. W., & Johnson, M. B. (1990). *Woodcock-Johnson Psycho-Educational Battery-Revised.* Allen, TX: DLM Teaching Resources.

A Revitalized Head Start Research Agenda: How Can Head Start Best Serve the Changing Needs of Children and Families in Poverty?

PRESENTERS: Michael L. Lopez, Louisa Tarullo

Michael Lopez: In coming to talk about ongoing Head Start research activities, we wanted to emphasize the important theme of "partnerships." Just as program providers have embraced the importance of developing and nurturing partnerships, not only with the families they serve but also with other providers in the community, we see the ultimate success of research as heavily dependent upon our developing strong, collaborative partnerships with each other. Thus, thanks to Gregg Powell's persistence and vision, we have been strengthening the collaborative ties with the program world via closer collaboration with NHSA and direct connections with providers.

As we look at the enterprise of research within Head Start, there is one fundamental question that drives our efforts: How can Head Start continue to demonstrate leadership as the premier national laboratory for the early childhood field?

Within this broad context, there are two questions that help focus the research efforts:

- How can research influence programmatic practice and policy decision-making?
- How can we help generate critically needed early childhood research for the field, not just Head Start?

When we consider research, it is important to remember that there are many different kinds of research that often serve diverse purposes. That is not to say that one is necessarily more important than the other, but rather to help us to appreciate different types of research and how they can be useful to their intended audience. Just as in every other part of our lives, there is no single answer or research approach—one size does not fit all!

One type of research is a descriptive approach that usually is intended to depict a particular program or group of children or families served, and in which the goal remains one of simply presenting the richness of the program or population. An example is the Descriptive Study of the Characteristics of Families Served by Migrant Head Start Programs.

Another approach is one that targets the implementation and operation of a program. The goal is to work closely with the program to help them articulate their "theory of change," or how their efforts will bring about specific changes in the children and families served. This approach is one that embodies the theme of partnership with the ultimate goal of fostering a mind set of "continuous program improvement," and is being used in the Early Head Start evaluation.

In the area of basic research, there is a greater emphasis on generating theoretical knowledge that will influence the child development community as a whole. The Head Start substudy of the NICHD Child Care Study is a good example of this type of research, where we hope to learn more about the natural developmental trajectories of children who have and have not been in Head Start.

The last area of research that I want to touch on is the area of evaluation research, which admittedly often receives the greatest amount of criticism and is the most misunderstood. In this case, the goal frequently is to assess the effectiveness of a particular program, specific service, type of management style, and so forth. In this general category of research, there also is a great deal of variation in how rigorous the research is conducted and/or how scientifically defensible the results might be (assuming successful implementation of the particular research design).

These are only a few of the major types of research approaches, but I wanted to lay them out in order to establish the appropriate context for talking about the Head Start research agenda. As we think about these different types of research approaches, we also have to be aware of the various purposes of the research as well as the different intended audiences.

All this being said, we now can turn to the current Head Start research agenda. In the past 7 years, there has been a dramatic improvement in the number and quality of Head Start research efforts. We have pushed hard not only to develop the highest quality research, but also to advocate for more partnerships, from the programmatic level to partnerships with other leading research agencies such as the NICHD, the NIMH, and the DOE. As a result, we have seen a significant increase in the number of top-notch researchers who have become interested in working with Head Start programs to develop high-quality research efforts. At the same time, we also have seen more programmatic interest in research, both as consumers of research findings as well as those interested in finding a way to conduct research within their own programs. Thus, the goal of stimulating more collaborative partnerships is alive and well, and growing stronger by the day.

Louisa Tarullo: Head Start is entering an historic period of reexamination, improvement in quality, and expansion of services. The size of the program, its comprehensive services, diversity of the population it serves, and the fact that it is federally funded suggest a role for Head Start as a national laboratory for best practices in early childhood and family support services in low-income communities. Because Head Start needs to expand and renew itself in order to assume its role as a state-of-the-art "technology," there is a concomitant and compelling need for a new, expanded, and formal role for Head Start research. *(Advisory Committee on Head Start Quality and Expansion, December 1993, p. 37)*

In order for the Head Start program to maintain its leadership role within the early childhood program and research communities, the overall set of research efforts also must lead the field in exploring new methodologies and strategies for the conduct of research. The report of the Advisory Panel for the Head Start Evaluation Design Project, *Head Start Research and Evaluation: A Blueprint for the Future* further recommends two principal questions around which research and evaluation planning should be organized:

1. Which Head Start practices maximize benefits for children and families with different characteristics under what types of circumstances?
2. How are gains sustained for children and families after the Head Start experience? (September 1990, p. 4)

It is critical that Head Start continue to invest in a set of research and evaluation activities which build upon the existing research investments and demonstrate responsiveness to the various recommendations contained in the "Blueprint" Panel report, the Advisory Committee on Head Start Quality and Expansion report, the 1994 Head Start Act, as amended, the National Academy of Sciences Roundtable on Head Start Research publication, *Beyond the Blueprint: Directions for Research on Head Start's Families*, and based on input from a number of key researchers from the field. The broad categories of Head Start research and evaluation efforts are summarized below, followed by a more detailed description of individual studies or activities contained within the six broad categories: (a) conduct new Head Start research focusing on quality and other policy issues, (b) conduct longitudinal research on children and families served in Head Start programs, (c) conduct intensive evaluation of services for infants and toddlers, (d) conduct studies of Head Start's other emerging innovative program strategies, (e) conduct studies of special subpopulations separately or embedded in larger studies, and (f) develop and enhance the capacity for research on Head Start in partnership with the larger child development community.

Conduct New Head Start Research Focusing on Quality and Other Policy Issues

Head Start has made dramatic progress toward developing an outcome-oriented accountability system, the Program Performance Measures Initiative, which can be used, on an ongoing basis, to determine the quality and effectiveness of Head Start programs.

Descriptive Study of the Head Start Health Component
This study was designed to provide a "national snapshot" of how local Head Start programs meet the medical, dental, nutritional, and mental health needs of the children and families they serve. Data were collected using a national probability sample of 1,200 children and families in 81 centers across 40 Head Start programs to provide current information on program procedures, community health risks, and health resources available to participating families. The final report has been completed and will be made available via the internet (http://www.acf.dhhs.gov/programs/rde).

Head Start Quality Research Center (QRC) Consortium
The objective of the Consortium is to create an ongoing partnership among ACYF, Head Start grantees, and the academic research community to enhance quality program practices and program outcomes. A cooperative agreement in September, 1995, established four quality research centers at the University of North Carolina-Chapel Hill; High/Scope Educational Research Foundation in Ypsilanti, MI; Education Development Center, Inc. in Newton, MA; and Georgia State University.

Head Start Performance Measure Center (PMC)
As part of the Head Start Quality Research Center Consortium, the PMC is responsible for the collection, analysis, reporting, and dissemination of data on Head Start Performance Measures. In the spring of 1997, the PMC conducted the first nationwide data collection as part of the Family and Child Experiences Survey (FACES). A report on the results of the spring 1997 data collection is expected in summer, 1998.

Head Start Family and Child Experiences Survey (FACES)
FACES is designed to collect longitudinal data on a nationally representative sample of 3,200 families with children enrolled in 40 Head Start programs, starting in fall, 1997. Its purposes are to provide descriptions of the characteristics, experiences, and outcomes for children and families served by Head Start and to observe the relationships among family and program characteristics and outcomes.

Conduct Longitudinal Research on Children and Families Served in Head Start Programs
Conduct longitudinal studies that seek to identify early and intermediate outcomes of a Head Start experience and that explore the interacting influences of preschool, family, and later schooling in mediating the long-term effects of child and family participation in Head Start. Build our partnership with ongoing longitudinal research which will provide valuable information about the characteristics and needs of the Head Start population, both parents and children.

Culturally and Linguistically Appropriate Services in Early Intervention: Research to Practice

CHAIR: Aquiles Iglesias
DISCUSSANT: Mary Ann Walker
PRESENTERS: Rosa Milagros Santos, Ann Higgins Hains, Bruce Ramirez, Dianne E. Rothenburg

As the 21st century approaches, the United States is becoming one of the most culturally, ethnically, and linguistically diverse countries in the world. Lynch and Hanson (1998) wrote that in 1997, the population of the U.S. was 267,305,109. Thirty percent of this number included individuals of non-Anglo-European ancestry. This number has more than doubled from 1970 when census reports indicated that 12% of the total population then were of non-Anglo-European ancestry.

A recent study reported that 32% of children under 5 years of age in the United States are of non-Anglo-European ancestry (Arcia, Keyes, Gallagher, & Herrick, 1993); by the year 2000, it is expected that 33% of the entire U.S. population will be comprised of individuals from traditionally underrepresented groups. Also by the year 2000, the U.S. population is projected to increase by 1% with nearly 60% of this growth from Latino and populations of color. Other researchers project that by the year 2080 the majority of Americans will be from populations previously described as "minority" with Hispanics/Latinos comprising the largest cohort.

Currently, in urban environments and in some states such as California, children and families once designated as the "minority" have become the "majority" (Garcia, McLaughlin, Spodek, & Saracho, 1995; Lynch & Hanson, 1993). Estimates suggest that by the year 2000, 38% of the US children under 18 will be from non-European-American groups (Hanson, Lynch, & Wayman, 1990). Projections suggest that in the coming years nearly 50% of all young children will be from cultural, language, and ethnic backgrounds that differ from the backgrounds of early intervention professionals. In 1991, nearly 20% of the children enrolled in Head Start nationwide spoke a language other than English (Kagan & Garcia, 1991); in 1994, 64% of the children in Head Start were of Latino, African American, Asian, or Native American ancestry (Children's Defense Fund, 1995). In 1996, this number increased to 68% (Children's Defense Fund, 1998).

Knowledge of these sweeping changes in demographics in America is widespread; however, there is a great need for information, materials, techniques, and strategies that are culturally and linguistically appropriate for the nation's growing populations. For early intervention and early childhood special education services to be effective, they must be tailored to the cultural and linguistic preferences and priorities of the families being served and they must be available and used by practitioners.

In the field of early childhood education and intervention, the focus on family-centered practice espouses the view that services for young children are to be offered within the context of the family (Garcia, McLaughlin, Spodek, & Saracho, 1995; Rosin, Whitehead, Tuchman, Jesien, Begun, & Irwin, 1996). Given the incredible cultural and linguistic diversity of families, professionals are likely to work with many families whose beliefs, values, customs, language, behav-

iors, and attitude are different from their own. Early childhood professionals will need greater understanding of the values and beliefs of these families in order to form effective and positive partnerships through the delivery of services (Hyun & Fowler, 1995).

Interestingly, many professionals working in early childhood, early intervention, and early childhood special education have not been fully prepared and/or have not had experiences working with individuals from various cultural or linguistic backgrounds. In order to educate professionals, training materials are needed. For example, appropriate and effective communication intervention is essential for the diverse population of young children with special needs. Language and communication skills are fundamental to the establishment of relationships with others, intellectual development, literacy achievement, and academic success (Nelson, 1993). Unfortunately, the available research literature provides limited guidance for appropriate assessment practices and effective and socially acceptable communication interventions for children from culturally and linguistically diverse backgrounds (Battle, 1993; Stockman, 1996). Additionally, few materials or curricula exist for personnel preparation (Lynch & Hanson, 1994).

The Culturally and Linguistically Appropriate Services (CLAS) Early Childhood Research Institute proposes to identify, evaluate, and promote early intervention practices that are effective, appropriate, and sensitive to children and families who diverge culturally or linguistically from the "majority" population. This symposium focused on the activities of the first year of the CLAS Institute by delineating the processes that we developed for conducting the cultural validity reviews and efficacy reviews and the future direction of the institute.

References

Arcia, E., Keyes, L., Gallagher, J. J., & Herrick, H. (1993). National portrait of sociodemographic factors associated with underutilization of services: Relevance to early intervention. *Journal of Early Intervention, 17*(3), 283–297.

Battle, D. (1993). *Communication disorders in multicultural populations.* Boston, MA: Andover Medical Publishers.

Children's Defense Fund (1995). *The state of America's children: Yearbook 1995.* Washington, DC: Author.

Children's Defense Fund (1998). *The state of America's children: Yearbook 1998,* Washington, DC: Author.

Garcia, E. E., McLaughlin, B., Spodek, B., & Saracho, O. N. (1995). *Yearbook in early childhood education: Meeting the challenge of linguistic and cultural diversity in early childhood education (vol. 6).* New York: Teachers College Press.

Hanson, M. J., Lynch, E. W., & Wayman, K. I. (1990). Honoring the cultural diversity of families when gathering data. *Topics in Early Childhood Special Education, 10*(1), 112–131.

Hyun, J., & Fowler, S. A. (1995). Multicultural consideration in promoting parent participation in developing the IFSP. *Teaching Exceptional Children, 28,* 25–28.

Kagan, S. L., & Garcia, E. (1991). Educating culturally and linguistically diverse preschoolers: Moving the agenda. *Early Childhood Research Quarterly, 6,* 427–443.

Lynch, E. W., & Hanson, M. J. (1993). Changing demographics: Implications for training in early intervention. *Infants and Young Children, 6*(1), 50–55.

Lynch, E. W., & Hanson, M. J. (Eds.). (1994). *Developing cross-cultural competence: A guide for working with children and their families.* Baltimore: Paul Brookes.

Lynch, E. W., & Hanson, M. J. (Eds.). (1998). *Developing cross-cultural competence: A guide for working with children and their families (2nd ed.).* Baltimore: Paul Brookes.

Nelson, N. W. (1993). *Childhood language disorders in context: Infancy through adolescence.* New York: Macmillan.

Rosin, P., Whitehead, A. D., Tuchman, L., Jesien, G. S., Begun, A. L., & Irwin, L. (1996). *Partnerships in family-centered care: A guide to collaborative early intervention.* Baltimore: Paul Brookes.

Stockman, I. (1995, April). *Demographics are change: Improving skills to better serve culturally and linguistically diverse preschoolers, their families, and communities.* Seminar presented at the National Black Association for Speech, Language, and Hearing, Milwaukee, WI.

■ Meeting the Need for Culturally and Linguistically Appropriate Early Intervention Services

Susan A. Fowler, Ann Higgins Hains, Bruce Ramirez, Dianne E. Rothenberg, Rosa Milagros Santos

The Early Childhood Research Institute on Culturally and Linguistically Appropriate Services (CLAS) is a federally funded collaborative effort of the University of Illinois at Urbana-Champaign, The University of Wisconsin-Milwaukee, The Council for Exceptional Children, the ERIC Clearinghouse on Elementary and Early Childhood Education, and the ERIC Clearinghouse on Disabilities and Gifted Education. The main goal of this institute is to expand and improve early intervention services for culturally and linguistically diverse children (birth through 5) and their families and to ensure that effective practices are available to personnel responsible for serving these families. The CLAS Institute identifies, evaluates, and promotes early intervention practices and preschool practices that are sensitive and respectful to children and families from culturally and linguistically diverse backgrounds. Specifically, the four goals of the CLAS Institute include:

1. To create a resource bank and catalogue of validated culturally and linguistically appropriate materials and documented strategies, prioritizing according to most prevalent populations in the US.
2. To conduct a rigorous review of materials by experts in the field of early childhood and in multicultural education, considering issues not only of effectiveness but also of social and cultural acceptability to culturally and linguistically diverse populations.
3. To evaluate and validate selected materials through fieldtesting of the materials with diverse populations.
4. To disseminate all reviewed materials and practices that meet the dual criterion of being effective and culturally or linguistically appropriate to all relevant stakeholders.

The CLAS Early Childhood Research Institute anticipates that gaps in practices and materials will be identified through the process of collecting, cataloging, and evaluating existing materials. In some instances, gaps will represent cases in which available materials or practices have not been fieldtested with specific populations and consequently the social acceptability and effectiveness of these materials and practices with these groups will be unknown and will warrant investigation through fieldtesting. In other cases, no materials or practices will be available and new research and development will be required to fill the void. CLAS proposes to fieldtest materials for social acceptability, efficacy, and fidelity.

The CLAS Institute has several basic assumptions, which define and guide its work:

1. Individuals and families are not simply members of a culture. All people are members of multiple subcultures. Given this diversity, no two families are alike. (Although the CLAS Institute will review some materials in terms of their relevance for specific cultural or linguistic groups, the reviews must always consider the individuality of the children and families served. Intragroup differences prevent the wholesale application of a single approach to all children and families within that cultural group.)
2. Cultures are dynamic and change over time (and culture changes faster than terminology often used to describe it).
3. The concept of cultural competence for personnel is a process not an outcome. Seeking cultural competence is a life-long process of learning in which knowledge and skills are acquired. It begins with increasing awareness of one's own culture, extending awareness to cultural differences and eventually to acquiring the skills and/or experiences to function effectively in another culture. It may be more appropriate to refer to this concept as increasing cultural competence.
4. It is important to identify a range of strategies or approaches from which users (practitio-

ners, families, and researchers) can make a reasoned selection of what may be most appropriate in a particular context. In terms of building our database, this means that we must move beyond a description of products or practices and the population groups with which they have been implemented. We should avoid culture-specific recipes for intervention, as only inappropriate stereotypes will result. However, it will be important for users to know what interventions have been used with what groups. It will be critical for us to synthesize within each topic (motor skills) or theme (e.g., child intervention) the array of products or practices that have been used and are reviewed as effective and potentially culturally appropriate.

5. Acquisition of materials should be guided by two contexts: (a) materials address the intersection of two or more features (early childhood, cultural diversity, disabilities or at risk) and (b) they are appropriate for practitioners, family members, administrators or academicians, particularly those engaged in personnel training.
6. Products resulting from the Institute must be "user-amorous" if we are to have any impact on practice. We are writing and developing materials primarily for consumers (service providers, families, and administrators) and secondarily for other academics. This requires that we consider multiple formats for communicating. It also specifies relevance for users and sensitivity regarding language.
7. Three principles should guide our dissemination of reviewed materials: (a) Our products should help people to ask better questions; (b) They should also provide information sufficient for consumers to make decisions and not advise or prescribe solutions; and (c) Whenever appropriate, we should link to the ERIC database for materials which merit description only and not a field review (i.e., those that do not fit our criteria for field review—see #5 above), as we do not want to duplicate the ERIC database. In order to get materials into the hands of the users, we must pursue CD-ROM and paper formats as well as an Internet-based format.
8. The work of the Institute will involve practitioners, families, and researchers/academics as field reviewers, advisory board members, fieldtesters and evaluators.
9. The work of the project is developmental in nature. The topic of culture and what practices are culturally appropriate is very challenging and complicated. We need to recognize that differing views will be a feature of this Institute. It is important that the Institute promote and encourage an environment where participants can discuss sensitive issues and where differing perspectives and views are shared in a respectful and constructive fashion.

The first step in developing acquisition criteria for materials was to identify the target audience. The list of consumers includes practitioners who are working with young children and their families, faculty engaged in the preparation of personnel from early intervention/early childhood special education disciplines, family members, and other consumers such as administrators, teachers, researchers, students, and the general public. The acquisitions criteria encompassed broad parameters of materials that: (a) addressed culturally and linguistically diverse populations, (b) were primarily concerned with children ages birth through age 5 and their families, (c) were concerned with children with disabilities or children at risk and their families, and (d) are of a practical rather than theoretical nature.

The second step was to define the types of materials to be collected. The CLAS Institute is including materials such as: (a) training materials for early intervention/early childhood special education personnel, (b) information packets for parents and teachers, (c) resource materials, curriculum guides, and manuals, (d) books, book chapters, and journal articles, and (e) videotapes, audiotapes, and multimedia kits. Materials received by the CLAS Institute were then sorted for the database by a review of the criteria in three areas: Early Childhood, Special Education/Disabilities/At-Risk, and Cultural and Linguistic Diversity.

The first stage of the review process began with a synthesis of current research and the examination of the DEC-recommended practices identified by the Division for Early Childhood (Odom & McLean, 1996) and the developmentally appropriate practices delineated by the National Association for the Education of Young Children (Bredekamp & Copple, 1997). Criteria for the review of materials emerged from the synthesis of the literature. National reviewers with expertise and representation in cultural and linguistic diversity and with expertise in various early childhood and multicultural topics applied the criteria to the materials. The results of the reviews will inform the CLAS Institute as to the future direction of materials and guide the research.

Identification of potentially significant practices will be an important focus of the CLAS Institute. Existing materials and practice will be collected, cataloged, and reviewed (described in symposium paper 2). Once final reviews are obtained from the field reviewers, the materials identified as both culturally and linguistically appropriate and evidencing effective practices will be reviewed and synthesized. The results of this synthesis will allow the identification of: (a) materials and practices which are validated with specific culturally and linguistically diverse populations; (b) materials and practices which are promising with specific culturally and linguistically diverse populations and may merit further field testing; (c) materials and practices which are effective with specific cultural or linguistic groups and hold promise for being effective with other cultural and linguistic populations and may merit further fieldtesting across diverse groups; and (d) areas of the literature in which few or no practices or materials have been developed for culturally and linguistically diverse populations.

Gaps in practices and materials identified through the review process will be addressed through new research and development. Field-test sites will be identified for evaluating materials with Hispanic/Latino, African American, Native American, Asian, and Pacific Islander communities as well as with the Deaf community. Subgroups within these larger populations will be tapped for assessing degree of generalizability across different cultural and linguistic groups. The research studies to be completed through the CLAS Institute will grow from the process of reviewing and evaluating materials and potentially significant practices. Studies will be developed for a variety of purposes, including fieldtesting and validating existing materials across various cultural and linguistic groups and testing and validating recommended practices across various cultural groups. A variety of designs will be used, both within and across studies, depending on the research question being addressed and the types of research needed. The goodness of fit between the research design and the cultural preference of the participants will also be an important consideration. In all instances, participants will be involved in decisions related to research design.

Dissemination is an ongoing effort by the CLAS Institute using state-of-the-art technology including a variety of mediums such as electronic, print, and video. The CLAS Institute envisions a resource bank that is an online, fully searchable database of key bibliographic and subject-indexing data, plus an abstract on each of the materials and documented strategies that are selected for any level of dissemination. This database would be made available, free of charge, to Internet users. In addition, the database will be made freely available in other media, which may include CD-ROM, quarterly print catalogs of items added to the database, and periodic listings of materials on selected topics or in particular languages.

Information will be disseminated through networks, which are likely to disperse the information to various cultural or linguistic groups as well as to programs preparing service providers to work with diverse populations.

The review and synthesis of practices and materials will be entered into the CLAS Institute's database for access to other researchers who may be interested in pursuing research in this area. An outcome of the work of the CLAS Institute will be a monograph and a textbook publication identifying and describing existing practices and materials that are culturally and linguistically

appropriate. The process by which the CLAS Institute reviews the materials will be highlighted in the text so that it may serve as a model for future review and validation of materials.

References

Bredekamp, S., & Copple, C. (Eds.) (1997). *Developmentally appropriate practice in early childhood programs (rev. ed.)*. Washington, DC: NAEYC.

Odom, S. L., & McLean, M. E. (Eds.) (1996). *Early intervention/early childhood special education recommended practices.* Austin, TX: Pro-Ed.

African American Families: Values, Beliefs, and Parent-Child Communication

CHAIR: Evelyn F. Luckey
DISCUSSANTS: Carolyn H. Jarvis, Thomas M. Reischl, Linda M. Kolbusz
PRESENTERS: Diana T. Slaughter-DeFoe, Cynthia A. Esposito, Jeanette M. Gassaway, Frances A. Campbell

The papers presented in this symposium examine various aspects of the culture and ecology of African American families from the midwestern, southern, and eastern areas of the United States. The research reported examines parent-child communication about race, the impact of chronic poverty on parenting styles, the relationships between maternal education and school success, and links between parental values, beliefs, and practices and children's school achievement. Despite the variation in topics, the research studies are linked by their focus on the socialization of African American children and sample characteristics. A majority of the families and children in the studies participated in Head Start and are part of the national sample included in the National Head Start Public Schools Early Childhood Transition Demonstration Study.

This symposium provides further opportunity to examine the ecology of the African American family. Papers presented both challenges to and confirmations of previous theories about the roles of families in the socialization of African American children. The paper on the importance of maternal education confirms previous findings about the mediation influence of the mother's academic experience upon the child's achievement. The paper on religious values and practices challenges some previous research on parental religious fervor and child outcomes in school. Papers on racial socialization and the impact of chronic poverty report findings that raise questions about ethnic sensitivity and the potential effects of welfare reform. Discussants provide perspectives that reflect traditional developmental, cultural, and ecological approaches and consider implications of the findings for Head Start and public school classrooms.

■ Maternal Education and Ethnicity as Cultural Mediators of Early School Adaptation

Diana T. Slaughter-Defoe, Eboni Howard, Rachel J. Cooper, Sharon Ramey, Craig Ramey, Carl Brezausek

Maternal education is a social address marker that has been consistently identified as a critical and powerful predictor of the educational success of children and youth. In the interdisciplinary human development field, research on the family's contribution to achievement, socialization, development, and performance is so important that the belief about the influence of the mother's education is rarely challenged or explored in depth. The research questions in this field typically have been studied without reference to intracultural, cross-cultural, or cross-national considerations. This research, using data from the National Head Start-Public Schools Early Childhood Transition Demonstration Study, provided a unique opportunity to examine the contribution of maternal education to initial indicators of children's school success.

Using a data set of 2,279 Head Start-eligible maternal and child respondents, findings on four questions were reported: (a) Is the impact of the mother's education upon a child's initial school adaptation still significant within contemporary poverty populations? (b) Is the impact similar within broad ethnic group categories, specifically, European, African, Latino, and Native

American populations? (c) Does maternal birthplace affect obtained relationships? and (d) When other risk factors associated with poverty status are correlated with four separate indices of adaptation, do education and ethnicity contribute to obtained child outcomes? Data were obtained from two cohorts of comparison group mothers about familial characteristics and themselves in the fall of their children's kindergarten year and from assessment of the children of these women at the beginning and end of kindergarten. Instruments used were the PPVT-Revised, the Woodcock-Johnson Reading and Mathematics Achievement Tests-Revised, and standardized kindergarten teachers' ratings. Independent variables included mothers' years of education, ethnicity, and immigrant status. Dependent variables included the composite kindergarten teachers' ratings, the Woodcock-Johnson test scores, and the PPVT scores. Intervening variables included household income, number of children in the home, household family composition, maternal workforce participation, language spoken in the home, and maternal health and feelings of depression.

Among native-born groups, years of maternal education were significantly correlated with the four indices of school achievement for three of the four groups: European American, African American, and Native American. Within the immigrant groups, years of maternal education significantly correlated with only one achievement index in the Latino subgroup: the PPVT. There was a similar trend in the African American subgroup. Years of maternal education best predicted achievement, even in comparison to income level and number of children.

■ Minority Parenting and the Stress of Chronic Poverty

Cynthia A. Esposito

Families living under chronically poor, urban conditions face daily what Pierce (1975) described as "mundane, extreme" stress. The nature of this type of stress tends not to be event-specific; instead, individual stressors tend to be ongoing and interactional, building upon each other to create pervasive, entrenched, and contagious conditions (McLoyd, 1990). For families beset by the mundane, extreme stress of chronic poverty, the parenting context may be even more critical to child outcomes (Slater & Power, 1987).

The purpose of this research was to explore the relationship of the stress of chronic poverty to parenting styles found in a low-income, urban, ethnic population. Stressors on parenting emanate from the environment, the family, and the child, and for the purposes of this study were categorized as such. Parenting constructs were created utilizing the Parenting Dimensions Inventory—Short form (Slater & Power, 1987). Data from this scale were factor analyzed; LISREL confirmatory analyses yielded four factors: (a) Encouragement, (b) Adherence to Rules, (c) Non-reciprocal Communication, and (d) Power Control. Parenting style groups were created from these constructs.

Statistical analyses, including correlation, regression, and ANOVA, revealed significant relationships between child, family, and neighborhood stressors and parenting constructs and styles. Discriminant analysis revealed a combination of stressors which together account for more than 40% of the difference between parenting groups.

References

McLoyd, V. (1990). The impact of economic hardship on Black families and children: Psychological distress, parenting, and socioemotional development. *Child Development, 61*, 311–346.

Slater, M. A., & Power, T. G. (1987). Multidimensional assessement of parenting in single parent families. *Advances in Family Intervention, Assessment, and Theory, 4*, 197–228.

■ Faith, Family Circumstances, and Children's Academic Achievement

Jeanette M. Gassaway, Mona Ibrahim

The purpose of this paper is to examine the relationship between parents' faith and children's academic achievement. Previous research has viewed religious activities such as church attendance, prayer, and religious beliefs in the lives of individuals as a coping mechanism and has provided some evidence that these activities are related to psychological well-being (Brown & Gary, 1991; Ellison, 1993; Pollner, 1989; King & Schafer, 1992; Maton, 1989; Ross, 1990; Sherkat & Reed, 1992). In addition, there is research that links parental psychological states to difficult life circumstances, revealing that difficult life circumstances are a primary predictor of symptoms of distress. Moreover, studies have found that children's social-emotional well-being is influenced by parents' psychological health and well-being (McLoyd, 1990). Prior research provides a basis for understanding how family circumstances and parental psychological well-being can have both direct and indirect influences on children and how religion and religious activities can play a role in affecting outcomes. In this research, we support the view that children's behaviors can be influenced by family circumstances and parental well-being, and that religious activities and beliefs can attenuate the psychological stress that is often associated with difficult circumstances. However, we propose that faith is a major force that predicts both psychological well-being and difficult life circumstances, enhancing the circumstance of life. We have proposed and tested a model in which the relationship between parents' faith and children's academic achievement is mediated by the amount of difficult life circumstances parents encounter and their sense of psychological distress.

Multiple regression equations confirmed the hypotheses that faith and children's academic achievement are indirectly related and mediated by the amount of difficult life circumstances parents encounter and their sense of psychological distress. In addition, it supported the hypothesis that faith was a determinant of family circumstances. After controlling for parents' age, employment status, educational attainment, and number of children, the results indicated that parents with higher levels of faith had fewer difficult life circumstances than parents with lower levels of faith. Parents with fewer difficult life circumstances had few symptoms of psychological distress. In addition, children of parents who had fewer symptoms of psychological distress had higher achievement scores.

This study has examined children's academic achievement from an ecological perspective in which familial domains have been included. It contributes to our understanding of faith and children in several ways beyond what the current literature reveals. For many, faith is not just a function of church attendance and generic attitudes about religion. This way of life becomes beneficial by enhancing the quality of life for those who embrace religious beliefs and activities. Second, it examines the relationship between faith and children's academic achievement. Children's primary social milieu is the family, and parents are ultimately responsible for their children's growth and development.

References

Billingsley, A., & Caldwell, C. H. (1991). The church, the family, and the school in the African American community. *Journal of Negro Education, 60*(3), 427–439.

Body, G. H., Stoneman, Z., & Flor, D. (1996). Parental religiosity, family processes, and youth competence in rural, two-parent African American families. *Developmental Psychology, 4*, 696-706.

Duncan, G. J., Brooks-Gunn, J., & Klebanov, P. K. (1994). Economic deprivation and early childhood development. *Child Development, 65*, 296–318.

Ellison, C. G., & Gay, D. A. (1990). Religion, religious commitment, and life satisfaction among Black Americans. *The Sociological Quarterly, 31*(1), 123–147.

Entwisle, D. R., & Alexander, K. L. (1995, May). A parent's economic shadow: Family structure versus

family resources as influences on early school achievement. *Journal of Marriage and the Family, 57,* 399–409.
Hadaway, C. K., Marler, P. L., & Chaves, M. (1993). What the polls don't show: A closer look at U.S. church attendance. *American Sociological Review, 58,* 741–752.
Jackson, L. E., & Coursey, R. D. (1988). The relationship of God control and internal locus of control to intrinsic religious motivation, coping, and purpose in life. *Journal for the Scientific Study of Religion, 27*(3), 399–410.
McLoyd, V. (1990). The impact of economic hardship on Black families and children: Psychological distress, parenting, and socioemotional development. *Child Development, 61,* 311–346.
Pargament, K., Olsen, H., Reilly, B., Falgout, K., Ensing, D., & Van Haitsma, K. (1992). God help me (II): The relationship of religious orientations to religious coping with negative life events. *Journal of the Scientific Study of Religion, 31,* 504–513.
Pollner, M. (1989). Divine relations, social relations, and well-being. *Journal of Health and Social Behavior, 30*(1), 92–104.

■ A Qualitative Description of African American Parents' Socialization Practice Related to Ethnic Identity

Frances A. Campbell

Children's sense of their ethnic identity has been cited as predictive of academic performance (Witherspoon, Speight, & Thomas, 1997), self-esteem (Phinney, Cantu, & Kurtz, 1997; Smith & Brookins, 1997), and empathy and altruism (Jagers, Smith, Mock, & Dill, 1997). Many believe individuals who strongly identify with their own ethnic group are more accepting of others (Berry, 1984; Cross, 1991; Phinney, Ferguson, & Tate, 1997). The development of ethnic identity has been linked to supportive families (Walker, Taylor, McElroy, Phillip, & Wilson, 1995).

The present study examined qualitatively what parents reported doing to foster ethnic identity in children. One hundred and seventy-seven low-income parents of primary grade children in a Head Start Transition Demonstration Program were asked what they were teaching their children about racial identity and strategies for getting along with others and what ethnic concerns children had raised. The sample was 81.9% African American, 2.8% Hispanic, 2.8% Caucasian, and 1.7% "Other." Nine families who refused to give themselves an ethnic label constitute a "Refused" group (5.1%). Interviewers were African American or Caucasian. Families were from the Southeast and lived in both segregated and nonsegregated neighborhoods.

All families responded to questions about their intentions with respect to teaching about ethnic identity. Most (62%) had discussed with their children what it means to be a member of their particular ethnic group; others planned to do so eventually (27%). A few (10.7%) had no plans to do so.

All families answered open-ended questions about the content of ethnic teaching and socialization practices, but the number of non-African Americans was too small to permit generalization from their responses. The rest of the findings, therefore, are based only on the African American parents. As described, the ethnic identity teaching within this sample of African American families was characterized by diversity. Many parents said they were teaching children to have pride in their own ethnic group. Interestingly, almost half of the parents first stressed the importance of treating everyone as equal, regardless of race, when asked about ethnic identity. Many wanted their children to know about African American heroes and their accomplishments. Some had discussed the questions of physical differences (hair, skin color). Racism was a concern for many, and they warned their children about discrimination.

Parental advice for getting along may be summed up as espousing the Golden Rule: "Treat others as you want to be treated." A variation of the Golden Rule was: "Treat others the way they

treat you" (implying retaliation if ill-treated). Typically, parents urged children to ignore rejection by another child and "be friends anyway." No parent had advised a child to seek friends only among his or her own ethnic group. Having good manners and being "nice" or "friendly to everyone" were the behaviors parents were trying to encourage.

Less than a quarter of the children had as yet raised questions about ethnic concerns. From questions parents did describe, it was apparent that children were aware of racial differences and were seeking to learn how to negotiate them in their lives.

References

Berry, J. (1984). Cultural relations in plural societies: Alternatives to segregation and their sociopsychological implications. In N. Miller & M. Brewer (Eds.), *Groups in contact: The psychology of desegregation* (pp. 11–29). Orlando, FL: Academic Press.

Cross, W. (1991). *Shades of black: Diversity in African-American identity.* Philadelphia: Temple University Press.

Jagers, R. J., Smith, P., Mock, L. O., & Dill, E. (1997). An Afrocultural social ethos: Component orientation and some social implications. *Journal of Black Psychology, 23,* 328–342.

Phinney, J. S., Cantu, C. L., & Kurtz, D. A. (1997). Ethnic and American identity as predictors of self-esteem among African American, Latino, and White adolescents. *Journal of Youth and Adolescence, 26,* 165–185.

Phinney, J. S., Ferguson, D. L., & Tate, J. D. (1997). Intergroup attitudes among ethnic minority adolescents: A causal model. *Child Development, 68,* 955–969.

Smith, E. P., & Brookins, C. C. (1997). Toward the development of an ethnic identity measure for African American youth. *Journal of Black Psychology, 23,* 358–377.

Walker, K., Taylor, E., McElroy, A., Phillip, D-A., & Wilson, M. N. (1995). Familial and ecological correlates of self-esteem in African American children. In M. N. Wilson (Ed.), African American family life: Its structural and ecological aspect. *New Directions for Child Development, No. 68.* San Francisco, CA: Jossey-Bass.

Witherspoon, K. McC., Speight, S. L., & Thomas, A. J. (1997). Racial identity attitudes, school achievement, and academic self-efficacy among African American high school students. *Journal of Black Psychology, 23,* 344–357.

Conversation Hour–Immigration and Migration and its Effects on Children and Their Communities

PRESENTERS: John M. Pascoe, Cynthia Garcia Coll, Howard Markel, Heike Thiel de Bocanegra

John M. Pascoe: This conversation hour is a follow-up of the plenary session on immigration and its effects on children and their families.

Abbie Raikes: Immigration is a difficult experience for children as well as adults, and the adjustment and assimilation period is quite difficult. What can we do to ameliorate those issues and what can we learn from history?

Howard Markel: One of the most prevalent themes that immigrants speak about is the old country versus the new—this is true of immigrant memoirs from a century ago and from today, from oral histories and focus group interviews. This is especially true for the adult or senior adult newcomers. They have the most difficult time adjusting to new cultural mores, a new language, and so forth. Children are actually quite adaptable to many of these changes—we have about 100 years of good data—particularly when talking about language and picking up aspects of a culture, such as the style of dress or slang. That is not enough, however; there are many problems that these children had in the past and still have today.

There are some lessons from the past that can help us today. We have a very different system of welfare or caring for the poor that is called the welfare state, even though some are trying to dismantle it. Prior to the 1930s that really did not exist in this country and charity was more of a private concern. Those with the wherewithal felt they had a responsibility to take care of others, and did so. I do not suggest that we dismantle the welfare state, but I do suggest that citizens need to do much more in terms of welcoming newcomers. There are a variety of ways that can be done. One way was for immigrants themselves to create an infrastructure of social groups. For example, there are such groups for Eastern European Jewish immigrants as well as for Asian and Latino immigrants. These groups continue to be formed today. One exception is for immigrants who arrive as a result of war or other catastrophe, such as Rwandans, where there is no time for an infrastructure of social groups to form.

I like to teach my medical students that there are many opportunities to help immigrants. This is not just for student doctors but also for public health workers, psychologists, social workers, and so forth. We need to go to immigrant communities in a more user-friendly way and take an activist role. I think that would be an important first step.

Heike Thiel de Bocanegra: I believe that one important variable when studying immigrants is the age they were when they immigrated. That is usually a very important factor in how fast the person learns English and adjusts in other ways. Senior citizens are frequently sponsored by their adult children and have a very difficult time adjusting. Some have been here for 20 years and still do not speak English and continue to need others to provide services for them. Sometimes we are more interested in length of stay, but I find that looking at age at immigration is more important.

Our community assessments, looking at how Russian immigrant children feel and how Puerto Rican immigrant children feel, found that there is a certain type of pecking order within groups of immigrant children. For example, Russian adolescent children who have been here for a longer time and already know English may make fun of the newcomers. They do not necessarily display solidarity and say, "I have been there, so now I will help you to adapt as well." They are sometimes the worst ones who make fun of and mistreat the newcomers. Another example is if children come from English-speaking Caribbean countries, some might make fun of their

accents. I am not sure whether there is an historical parallel to it, but it is certainly something we observed in several of the immigrant groups.

Markel: Immigrants at the turn of the century would be called greenhorns. The worst thing one could call a fellow immigrant—a newcomer—was a greenhorn. The people hardest on the greenhorns were those who had a small leg up on the socioeconomic ladder.

Question: Was this among children as well?

Comment: Very much so—children and teenagers.

Question: What are the similarities and differences between the early immigrant experience and the immigrant experience right now?

Cynthia Garcia Coll: When one picks up and leaves one's country, family, culture, climate, and so forth, it is because there is something that is really pulling that person away. This is something we need to take into consideration, and I think that it is very much a part of the immigrant experience. Some people are pushed to leave their countries and come here because of economic, social, or political reasons, and some choose to come here because the opportunities are greater. That is very much the same now as it was previously in our history. I agree that the age of the person when he or she immigrates is definitely important. As a developmental issue this is one of the main things I look at—the length of time one spends in a country before immigrating does have a bearing on adjustment.

Historically, there are some differences that I would like to mention—the racial and the ethnic differences of the earlier century and this current immigration wave. I know that early on one could tell very easily who was Polish or who was Italian, for example. However, by the second generation, they spoke English and adopted American ways and thus stood out less, even physically. I think that is a little different now. The difference right now is that we are seeing and talking about the colorizing of America. There is a sense now that even when immigrants learn English, they still look Black or still look Arab. I was talking with an Indian woman who told me that her 6-year-old son said, "Mom, can I become more White now that I'm in America?" Did he have the expectation that becoming American meant that his skin would change color too?

For this group, I question the notion that the second and third generations are going to do a little better.

The issue of education has also changed. I still think that a person can make it by working hard but now one needs 16–20 years of solid education to climb the socioeconomic ladder. With this new reality, how children fare within the educational system becomes much more critical. I do not know if dropout rates for immigrants have changed historically, but I think they actually might not have. I think there are many more high school graduates now than there used to be because the dropout rates at the beginning of the century were relatively high. Dropping out of school, however, did not have the negative consequences that it now does. I want to be sure that we keep track of both the continuities in historical process and the demands currently see because of the characteristics of the new immigration wave.

Question: Was there anti-immigrant sentiment at the turn of the century and was it similar in its fervor to the current anti-immigrant sentiment?

Markel: To be sure there was, and people were far less shy about how they expressed their petty bigotries or nativist feelings about immigrants. For example, on the front page of the *New York Times* on August 1st, 1892, there was a report of a cholera epidemic threatening to arrive in New York City from Hamburg, and the presumed carriers were Russian Jews. The article stated, "we

do not need these ignorant riff-raff coming to our doors as they will ruin the cities . . . . " That is just one example of the thousands I could quote. There is indeed a different wave of nativism today. Anti-immigrant sentiment is tied to diminishing economic resources for all: White, non-White, native, non-native. There are diminishing educational opportunities and the bar is much higher, requiring everyone to obtain a much more comprehensive education in order to move up. A high school education at the turn of the century would get a person into a very good white-collar position anywhere in the country. That is surely not the case today.

Another very important point is the "faces" of the new immigrant because it adds an element of racism. An Asian person will always have Asian features, and so forth. I believe that this fact will make the acculturation process longer than one or two generations, which was what we saw a century ago. I am hopeful that, even though it may take two or three generations, children will ultimately blend in. Their features do not look the same, but they are the same in terms of their lingo, dress, what they are doing, and so forth. I think it will take longer, though.

Comment/Question: I want to pick up on something that Heike mentioned about the outcomes for the second generation being better. This is true of Mexican Americans. Those who maintain less distance from their parents' cultural heritage have both better health outcomes and educational outcomes. The dropout rates are lower and the infant mortality rates are lower, even among people who are comparably poor. Do we need to rethink the idea that acculturation and assimilation are good things?

Coll: I agree that we need to rethink acculturation. I will talk a bit about some of us who are working with human development and acculturation. We now talk about biculturalism and about code switching as the main technique that children need to learn. They are very good at moving and shifting and things like that. What we find right now is that what happens with acculturation here is that it is acculturation to poverty. It is not acculturation to mainstream culture that many of our families are going through. So what one sees is a change in lifestyle from good nutrition and taking care of oneself during pregnancy to using drugs, smoking, and drinking. It is a different way of thinking about it than it was in the very beginning of the century, when acculturation was about learning English, getting a good education, and moving on. Right now there is not an open system whereby you learn English and immediately find a better job. That is not the way it works today.

We now use models that value maintaining one's ethnicity and cultural sense of self because that is what keeps a person connected to a family system that should not be lost. If a person has a sense of pride in who he or she is, they are less likely to feel so bad when they are treated badly by others. Our current models are not unilateral—straight assimilation and acculturation. They are geared more toward maintaining one's own culture while assimilating only in ways that are constructive, such as learning English to get a better education to move up the totem pole, rather than becoming acculturated to a lifestyle that is not good.

Thiel de Bocanegra: That covers my comment as well. I would add that not everybody who comes from South or Central America, for example, wants to keep their culture or stay rooted to that. We should just leave that as an option. To be bicultural or multicultural means that one can choose to stay connected but one can also choose not to, and we should allow that.

I just wanted to clarify a point. We talked about immigrants and about refugees, and I want to mention that how somebody comes over here is very important in terms of their ultimate health status. Typically, researchers found that if people come voluntarily as immigrants, undocumented or documented, their health status is a little bit better. This is true of Mexican Americans even compared to Mexicans in Mexico. One reason is that if a person already has cancer or another disease they are less likely to come to the U.S. The situation is different for refugees. It was previously pointed out that some people come from war-torn countries and

these people tend to have worse health indicators than the average citizen in the U.S. So when we talk about first generation immigrant infants having better birth outcomes than U.S.-born infants, we are typically talking about immigrants who come voluntarily, not about refugees who tend to have worse health profiles. The people most at risk of being neglected are those who are not recognized as refugees by the Immigration and Naturalization Service (INS). Typically, if people come as refugees, they receive a certain package of benefits: about 9 months of Medicaid, enrollment in a refugee resettlement program, and some a connection to some type of community organization to help them to adapt better. However, if people come, for example a recent group of Liberians who were escaping a civil war, and just overstay their tourist visas, it is a different situation.

Comment/Question: One of my concerns is extending mental health services to people, especially when they come from cultures where issues of mental health are not dealt with in the same way that we deal with them in this country. I do not know if any of you have had any experience with this, but it is a problem we run into frequently. How do we extend mental health services to both parents and the children who come from different countries?

Coll: What I have seen in terms of service utilization is that, for example, many populations are underutilizing these services, especially mental health services. In many cultures the idea of talking to a stranger about very personal problems is completely inappropriate.

There is now a movement within the mental health community to think about adapting our system service delivery for these situations. Jose Szaponick at the University of Miami has conducted research and has begun a training program. He works primarily with Cuban families, but since the demographics in Miami have been shifting, he is also now working with Central American families as well. He believes that one has to address the gaps not only in age—the generation gap—but the acculturation gap that he describes. Children and adolescents have to be able to listen and voice their differences, and parents do too. The adolescents have to understand where the parents are coming from—there is an old country and there are expectations and dreams—What are they bringing with them? What are their expectations for their children? The adolescents and the children must think about these issues. Another approach comes from the Fordham Center in New York. Lloyd Rogler has done work on acculturation and there is a great deal of literature from that group regarding what is important for the use of mental health services.

Thiel de Bocanegra: Mental health services should probably have a different name. At Bellevue Hospital Center, they call their facility the Bilingual Treatment Center. Sometimes when, for example, hearing or learning deficiencies are found in children, parents get scared. When they are recent immigrants this can be extreme. If a parent is referred for services, this means to them that the child is mentally retarded or crazy. The idea that one can go for preventive services is not in the repertoire of many people. How agencies address this is to avoid using the term mental health or psychology. One could say, "There is a counselor," or "I would like to refer you to somebody with whom you can talk a little bit more." There is a lot of education one has to do just to make sure that people feel comfortable with the fact that perhaps their child has attention deficit disorder or dyslexia, and to help them understand that it does not mean that their child is mentally retarded.

Comment: When I take histories from patients I am supposed to ask if there is any mental illness in their family. I skip over that and never ask it.

Thiel de Bocanegra: This is not a scientific answer to that but I was wondering how many people have ever had to apply for a tourist visa or a visa of any kind. When you apply for a visa

in an American consulate, you are asked certain types of questions because they want to screen you. You are asked whether you have active TB and or any kind of medical problems. They also ask you whether you are a convicted criminal and whether you are a Communist, and then they ask you whether you have mental health problems. Of course you have to say no to all of the above in order to enter.

Markel: I agree with you. Incidentally, not only are you asked about insanity or mental health problems and Communism, but also homosexuality and contagious diseases were all rolled up in one bill in the McCarren/Walter Immigration Act of 1950. It is a very disturbing sentence because it equates all of these issues to mean they are all a disease, they are all medicalized, and they all are excludable.

Question: What about AIDS?

Markel: If you announce at the consulate that you are HIV positive, that is the end of that trip as well. I think Heike's distinction between immigrants and refugees is very cogent and important. I see a lot of refugees in my practice, and many of them are coming from war-torn areas where they are being tortured and have textbook cases of post-traumatic stress syndrome. When asking these patients about their experiences, it is very difficult and I try to get to know them and see them at least two or three times before I ever get into that; and it is still very difficult because of the political ramifications. A patient might think, "If I talk to you, you might tell somebody else." There are many nuances that we all have to learn.

I am struck by how few mental health resources we have, not just for immigrants, but for everybody in this country. As a physician specializing in adolescence, it is very difficult to obtain mental health care for any of our patients, so it is really a dire problem for the immigrant population.

Pascoe: In any of discussion of mental health in 1998, the word "managed care" needs to come into the discussion. It is a major problem in Madison for the entire population but especially the indigent population. The county mental health facilities are swamped.

Comment: As you were talking, running down the list of categories of mental health problems, I began thinking about poverty and the extent to which many families who come from various parts of the world go to communities where they are in cramped spaces. Just dealing with the stress of immigrant life in the U.S. might then translate into mental health problems. Where is the dividing line, if we can see one, between dealing with the effects of poverty and mental health problems? In my experience, I see that the solution to the problem might be on a bigger level, whereas psychology is treating it as an individual problem.

Pascoe: Are you saying that in the face of these stresses in the transitions, anyone would become depressed? That they should be depressed otherwise there would be something the matter with them? It is normative?

Comment/Question: I guess what I am concerned about is the fact that the psychological community sees these things and puts them on the table of the individual families rather than addressing societal factors. How do we do that, particularly in our training where we are supposed to look at the individual?

Coll: I think what you are asking is whether we should be conceptualizing it as an individual's problem or as a reaction to a context in which they are living; exposed to so many stresses including refugee status, poverty, overcrowding, and so forth. I am a psychologist who believes

in context. I can never see an individual out of the context in which they live, but I know that this is a minority view in psychology. I used to think about Head Start and would say to myself, "I actually do not believe in Head Start." We create programs to address problems that would be better addressed by such ideas as redistributing income to try to eradicate poverty. I have shifted to a different place, because I know that that revolution is not going to happen in the next 10 or 20 years.

It is amazing when you go to Europe. I was just in London 2 or 3 weeks ago, and my children remarked to me, "Mom, you know I have not seen many poor people here." It is not that there are not poor people there, but my children were already noticing that there was a sense of well-being in people of all colors and they are not used to that. So I think it is something that we can do with our resources. The question is whether or not we have the will to do it. To a certain extent, programs like Head Start make us feel good as a nation; they justify the notion that we are doing something good for the poor. Yet, at the same time, as I say to people who are in policy positions, I would not like to give anything to other people that I would not give to my own children. Why are your children not in Head Start? It is not only in psychology that the thinking is that the individual needs to be treated and the context is forgotten. That idea is very much a part of how we think of ourselves as Americans, how much it is part of the history of this country, and how much we celebrate the individuals who make it against any odds. We tend to forget about the 99% who do not make it and say if 1 out of 100 can make it, then the other 99 can make it too.

That is a very narrow way of thinking about humans, and human development for that matter. Look at how welfare reform now talks about individual responsibility. All the responsibility is put on the individual; the notion of "you can make it." It would be much better to deal with how everybody can get a good education, good jobs, and good housing. Then maybe we would not need Head Start or mental health services. Maybe we would still need them, but at a very different level.

Question: Given our understanding and knowledge of development, do we not in effect serve as mediators, if not the gatekeepers, by our silence on many of these issues?

Coll: Absolutely. Again, that is what I am saying. Let us question Head Start. I mean I know that this is heretic to say in a conference like this—

Pascoe: You will not be invited back next time.

Coll: I know. I have been here three times, and I love this conference. Given the circumstances, I am in favor of Head Start, and I am glad that we are at least thinking about the children. However, I would love to challenge us to think even further and get past believing that children only need a half-day program and that will prepare them for school. A half-day program is surely not going to be able to deal with the violence and poverty these children experience. Let us think more profoundly. Let us think about whether we are really committed to bringing everybody to the standard of living that we want, or are committed to maintaining the gap, or actually widening the gap as is happening right now. How do we become activists? I feel as if we do not speak up, nobody will.

Markel: I agree, and I think we have a responsibility to be activists in our roles as physicians, health care providers, mental health care workers, educators, all of us. However, I do not think that just by ameliorating poverty we will cure all of these problems.

Coll: Wouldn't it be nice if we would try?

Markel: It would be a wonderful goal, and we ought to go for it. However, I do not think that

will happen in this country. There are stereotypical problems that groups of people tend to have when confronted with a new society, new language, a need to struggle and get ahead, living in poverty, cramped conditions, and so on. That does not mean that 100 out of 100 will fail when put into that situation, nor does it mean 1 out of 100 will succeed. What is going on is a very mixed bag. We need to look globally at the types of programs we are developing to help the poor of all groups, ethnicities, and backgrounds, but also look at what are we doing as health care workers and educators to promote the family, which is still the best single unit. There is no social program that can replace an intact family that loves and cares for its' children. So it is really a combination of both, and I think we as a profession have not been loud enough.

Question: What I hear you saying is that what we are doing is a drop in the bucket compared to what we need to do. What are your thoughts on how to go further as individuals? How would I, for instance, be able to do more?

Pascoe: From the perspective of helping immigrants or just helping the needy? Are we broadening the discussion now beyond immigration?

Coll: I think we are. There were 2 years that I did not speak, and they were my first 2 years in graduate school in the U.S.—I could not figure out what the hell was going on. Then after I figured out that this was a matter of speaking up, I have not stopped, and I do it everywhere I go. I take any opportunity that I have—if it is here or if it is with a cab driver. My sense is that in everything you do, you have to keep in mind how privileged we are, those of us who have managed to get out of whatever our situations were and to achieve the level of education that we have. One's life must be political: in our work, in our personal relationships, everywhere.

Thiel de Bocanegra: From a public health perspective, it is helpful to look at change within an ecological framework, where there is policy change such as laws and legislation. There is a system change and there are changes at the community, group, and individual level. People work at different levels. The teacher in the Head Start classroom works perhaps more with the individual students and with some of the parents, but certainly can impact some change at that level. I think for change to ultimately become effective, every level has to be changed—the policy level, the community level, and the individual level. For example, the New York Task Force on Immigrant Health, tries to facilitate change at all the different levels to promote immigrant health and better access to health care. However, we as the task force do not do much policy work, but we are linked to the New York Immigration Coalition, which is linked to the National Immigration Coalition, and they do lobbying for immigration reform. It is not that one works proactively in terms of immigration; it is more like efforts to restore food stamps.

It is a dual process. Even if you work, for example, predominantly with children in a Head Start setting, you still could try to have a policy impact by writing a letter or calling or being a part of a coalition. It may not be your main activity, but you have to think at all the different levels in order to promote change. That is how I would approach it.

Pascoe: Cynthia's comment reminds me of a quote from Marian Wright Edelman, the founder of the Children's Defense Fund. Her mother used to say even a little flea can make a big dog itch. What happens in child health that I have seen in the 20 years that I have been doing such work is that we get fractured and sometimes do not get along. Then there is the American Association of Retired Persons (AARP), a huge machine coming down the road. One of the reasons we have $24 billion for child care over the next 5 years is that AARP was behind it, as well as hundreds of other organizations. There is strength in numbers, but locally, we too can make a difference.

Markel: I agree that there is a full menu to choose from. There are a myriad of activities that we could all do, from helping a little child to talking to a Congressperson about someone who is having a problem, or a policy issue, or coming to Head Start. I was reading Charles Dickens' biography and he wrote a letter near the end of his life to his biographer whom he hired to follow him around. In this letter, Dickens said, "We are in this world to be of it and to make the best of ourselves and the world into the bargain." I think it is a good axiom to follow. There are many things we can do if we just get up and do them.

Comment: I have a quote to add from Alice Walker, "Human compassion is equal to human cruelty, and it is up to each of us to tip the balance."

A. Raikes: I spent 3 years working on Capitol Hill for a senator from Nebraska, a state that has not had much immigration in the past, but has now been faced with a new flow of migration because of the state's meat-packing plants—a very common industry in the Midwest. I wanted to respond to the comments about activism because I worked hard to try to increase the level of awareness, and it was very difficult and very frustrating. I do not know whether I did any good. Earlier in the conference, Dr. Curtis from the Milton Eisenhower Foundation spoke about how important it is for people like us to learn how to deliver our messages to the media. We need to make the messages concise and to make those points to counter what the other side is saying.

Markel: There is a real power too of knowing human stories. It is more powerful if you can talk about immigrants or refugees you know. However, staying on the level of the individual will not make the same impact. It is just rhetoric unless one goes to the other levels.

Comment/question: I have been working in Head Start programs on Mexican migrant farms for the last 2 years. These are situations where the farmers in the communities are entirely dependent on this the labor force, yet they ignored the laborers completely. No matter what we may think, improvements are not happening. If the laborers do not work, such as when it rains, they do not get paid. How do you approach a community where the total livelihood of that community is dependent on a migrant population that they ignore? How do you even engage them in the conversation? How would you approach a population that is so obviously blind to the needs of a vulnerable group?

Markel: I think it is very difficult. As you were speaking I thought about the lead paint slumlords I used to deal with in Baltimore. They would say, "We did not put the paint there so we are not responsible. If these mothers watched their children better..." I think you just have to keep on talking to them for a long time. It is a generational issue that might take a lot longer than other social problems.

Coll: I always feel it is easier to see oppression in other countries than in our own. In terms of the conditions of laborers we were talking about—how might we bring that to the attention of the media and make it explosive? Perhaps someone might bring the issue to the attention of a lawyer in the state, someone who is very interested in children's rights. If we cannot change things by talking, then we will have to try other ways. One needs to find other ways and build a coalition with people who are interested in human rights. People need to think about where the power is and how to make them aware, because I do not think making employers aware that they are being abusive is going to improve things, unless they are getting some heat from somewhere else.

Wanda Roundtree: This is a capitalist country, and we often make an impact with our pocketbooks. These farmers are obviously making money off of people and that is where the activism

really has to start. It reminds me of a very sobering experience that I had in Oregon just a few months ago. I have never seen poverty in the way that I saw it there. I was visiting a parent who was participating in the Home Instruction Program for Preschool Youngsters (HIPPY), an early intervention home-based program. The parent was a young, married, immigrant mother of three, and was working on a farm in Oregon. The trailer home she shared with a husband and three children is smaller than this table. The home visitors come from the public school systems, so somebody knows about this situation. How can it persist?

Coll: Bring in a reporter from a newspaper to write about it.

Roundtree: How can this happen in the United States of America? In the trailer park, there is no place for the children to play. The family was without hot water for months until the HIPPY program helped them get a used water heater. There is no place to take a shower; just a little trickling of water to pour on yourself to bathe. It is a deplorable situation. How can we treat human beings like this? I live in New York City, and when I walk up and down Fifth Avenue, I see dogs that are treated better. I do not know what it is going to take. We are suffering with this amnesia and are forgetting about those in need.

Markel: Humans' inhumanity towards other humans knows no depths. You can see this if you look across centuries. Back to the migrant issue, though. I was just thinking as we were all talking that we all go to grocery stores and buy from the same stores. Why not go to local grocery stores and say we are not going to buy our produce from you as long as we know that it comes from migrant labor living in deplorable conditions?

A. Raikes: Let us say that we did not buy the produce and then there is less money going to meat-packing plants and less money going to producers of agricultural products. The first people who are going to suffer from that are the migrant farm workers.

Comment: They could even be sent back to their home countries.

Comment: Cesar Chavez tried for many years in California to organize and raise people's consciousness about these issues for migrant farm workers. There have always been those involved in trying to make changes, either through activism or other means. We need to spend more time forming coalitions of like-minded people who want to work together. People tend to be concerned about their own families, their own jobs, and what is happening in their lives now. I do not think that people are willing to listen or be sympathetic because it takes a lot of time. I do not think that change can truly come about as long as most people live comfortably. People do not want to see a change until something is really hurting them, because we do not like change; it is painful. At the same time, the pain that can be taking place among families and children is tremendous and all we can do is keep working on it. I think that people in the field are working hard on strategies and trying to make those strategies work. However, I think it is a societal issue. It is ingrained in the system. It is not an issue in which individuals can simply create a coalition to make changes.

Pascoe: In contrast to what was said about our being too comfortable to work for any change, a recent survey indicated that a significant number of people thought that it would be okay to give a little bit to bring about some of these social changes because they are so comfortable and are not feeling threatened now. Sometimes when things are going well, people can nudge the political process in that direction.

Comment: There is a theory that says our country goes in 15-year cycles. So for 15 years, we focus on the individual and the economic marketplace, and then for 15 years we focus on humanitarianism and issues of justice.

Markel: There is a problem with that. The book you are citing is Arthur Schlesinger's *Cycles of American History*, and he based it on the work of his father, Arthur Schlesinger, Sr., who wrote a very influential essay about these 15- or 20-year cycles of liberalism versus conservatism. We were supposed to go into a liberal phase in 1988 to 1989 based on those criteria. So it is very hard to historicize something in exactly 15- or 20-year cycles. It is a curve of peaks and troughs, but it is not just comfort level in terms of economics, it is comfort level in terms of what kind of country are we going to be, or what the face of the country is, and how people feel about newcomers at different points of time. There are many reasons one can feel threatened by newcomers aside from economics; health is just one of them.

Comment: I think enough members of the middle class are going to go into managed care and remain there. I would like to look at changes in managed care and this expansion of child health insurance as two possible indicators of moving in certain directions.

Thiel de Bocanegra: When you posed the questions about the rural farmers, I tried to think about how one could bring about change. One solution is working in coalitions, working with the ones who are more open and willing to change, and with the more liberal farmers. It is interesting that all of us on this panel work in cities, and, typically, we tend to then provide city solutions—let us boycott and so on. We have to be aware that normally in most countries of which I know, persons living in rural areas tend to be more conservative and have more conservative political attitudes than people living in urban areas. I think we have to de-urbanize our social issues. In New York State, people in Albany or upstate New York say a problem is only a New York City problem. For years immigration was a New York City problem; as were AIDS, gun violence, drugs, and crime—everything was a New York City problem. If one wants to do anything at the state level and get it done by the politicians in Albany, one has to make sure the problem is also a problem in the rural, mainly White-dominated areas of the state. Try to stay away from always seeing problems from an urban viewpoint. Sometimes we tend to be a little bit more paternalistic because we in urban areas think we have found the solutions.

We also need to make sure that immigrant groups, such as the Latino population, stays unified. How can we expect the non-Latino White person to feel sympathetic when some Latinos are unsympathetic to newcomers? Some feel that because they made it, the rest should not enter the boat. So we have to work on that one as well.

Coll: What if it had been Germans who were here in large numbers? Could you imagine having Germans united, the whole population here united with one political view?

Thiel de Bocanegra: Not with one political view, but what one finds sometimes, for example, is that people could help each other and could share this idea of saying okay, we have to help push some legislation through.

Coll: I am much more into coalition building that cuts across ethnic and national lines.

Thiel de Bocanegra: I think both should be done.

Coll: About 6 weeks ago, we had a fabulous meeting in Providence with the Jewish and Latino communities. What was very interesting about that meeting is that the Jewish community is very comfortable but they were looking at us as the up-and-coming community. They were thinking

very selfishly, and we could talk about this. They were saying that their community is not growing, and was actually decreasing in number in the U.S.—from 6 million to 4 million—and discrimination continues to be an issue that is important to their community; there is always the concern that what happened in Germany could happen to them again. Another issue for them was that when they get old they worry who will take care of them. If the Latino community is the largest-growing community in the state, with the highest fertility rate, and 60% of the young people drop out of high school, they were thinking, "What is that going to mean to us?" It was a fascinating experience because it was not altruistic. This was not a case of wanting to do charity; this was something that really has an impact on the well-being of the entire community. We have been very good at knowing how to take care of our own. Now let us see if there is anything that we can learn from each other. In the meeting, I could see that the people were being very selfish, but in another sense they are aware that their existence is connected to everybody else's. There was a sense that if you do better or have a certain quality of life, I am going to be better too.

Aquiles Iglesias: I do not think that we as a country have realized some of the things you were talking about. In my county, Chester County, the most conservative county in Pennsylvania, 80% of all the mushrooms grown in this county are grown there by Mexican-Americans who live in deplorable conditions. The problems are not isolated city problems; they are in every single community and in every single state. A friend from the Indiana Training Institution, for example, says things such as, "We do not have to worry about training bilingual speech and language pathologists because we do not have that many bilingual people in Indiana." If he would get out to Bloomington, he would realize that it would be appropriate to have bilingual pathologists. We as a country need to think of the future and this dependency we all share. I would love to say, "Who in the hell is going to pay Social Security for you?" When President Clinton was in China, the students had an interview with him at the University in Beijing. One of the students asked him, "What are the problems in your country?" Clinton was rather taken aback because while he knows that there are problems, our leaders are usually not asked what they are. We always tell other people that they have a problem here and a problem there, but nobody ever asks us about our problems. I was so pleased that these four Chinese students asked those questions. Unfortunately the news media did not carry those questions, but it was really important for outsiders to be asking those questions and saying, "Do not tell us how to run our country. What are your problems? What are your solutions to these problems?"

Coll: I remember we were all against apartheid and I was saying to my students, "Take the bus to South Providence and visit apartheid. You do not have to go to South Africa to see it—Apartheid is right here, living and thriving." Make those problems an issue. Keep saying that if the next generation does not get educated everyone's Social Security is going to go down. Make a point of always saying that and making people aware that the situation is not as comfortable as they think. Some people say that immigrants are taking their jobs, but what jobs are we talking about? Those are jobs that we do not want to do. To a certain extent, I do not mind cleaning toilets if it is only going to be a part of my life, and then I am going to be able to move on. That is the immigrant's dream.

Comment/Question: Being an advocate, the last thing I want to have happen is for people to turn their backs and say, "Well, here she comes again. I am sick and tired of hearing her. I mean who does she think she is? She thinks she has all the answers and is going to come and tell me how horrible I am." There is also that reality. I think that it is the responsibility of those of us in research in human development to find answers to some these questions. How do we learn as human beings to communicate better? I am in the field working and trying to find solutions, but I think that the scientific world needs to do more of that piece to help us to develop strategies to promote change.

Markel: I could not agree with you more that we have to put this problem in the historical context. I think that is a great idea because, as I was saying earlier, many things that we do in the present—not just Americans, you can find it in any national context—are based on things that are culturally embedded from the past. That is certainly true of how we deal with immigrants and with so-called "socially undesirable social groups." These studies need to be done. However, here is the flip side. We, as a nation, do not pay attention to historical context very often. Oh, that was yesterday. Yesterday? This is 50 years ago, 100 years ago, 1000 years ago. I knew this to be true when I was a medical student and someone mentioned that last week's New England Journal of Medicine was ancient history. Tell that to the guy who was in last week's New England Journal of Medicine, but nevertheless, we do not like to listen to that.

We do not like to learn from the past. We also do not like to hear outsiders telling us about our problems. That is a very unique part of the American character. We think of "other people," the refugees in wherever or the famine in wherever, and we glance outward on certain issues, but are not terribly good at inward glances. How do we change the American character? I think this is also true of education and research. You have to do the research, but if it is not accessible and not presented by all of us in a way that is understandable and "user-friendly," then we are wasting our time and spinning our wheels. I do not think researchers have been responsive enough to that particular issue.

Comment: I wanted to point something out. I am from Venezuela and have been here 9 years. I was shocked when I came here and heard people calling Venezuela a Third World country. In my country, Social Security was actually social security. If I got sick, I went to the doctor. I did not have to pay. During the time I was at the doctor, those hours were paid as work hours. If I came back with a slip that said I was sick and had to stay home 3 days, my employer had to pay those 3 days as work. If I got pregnant, the employer had to pay for 3 months of prenatal and 3 months postnatal care. If I agreed, as soon as those 6 months ended, I could go back to work in the same position. So I said, "Wait a moment. Where are the problems? Are they back in my country or are they here?"

That was one of the shocks. The other one was learning that professionals—mathematicians, doctors of medicine with long years of experience—are not recognized as professionals here. Their titles are not recognized, and they must start again from the beginning. I began cleaning in a kitchen when actually I am an architect. Immigrants are not only people from rural areas who come to this country to find work. They also come from cities and have left behind all of their possessions because of political issues or whatever. They are professionals, and they did not come here to clean toilets, as you say. The first thing they need to do is to provide for their family; they need to work in whatever they can find. In my opinion, it is a waste of human resources. I am trying to be an advocate for those families with whom I am working, and for myself of course, because I have gone through that. Sometimes when we say we have to provide them with an education, that is not true because they already have that—they have come with that already. Language is a primary issue. If you do not speak English, you cannot succeed in anything here unless you stay in your separate community and hold the kinds of jobs that nobody wants just to survive—pay for food, rent, and take care of clothing for the children.

Markel: I have one question that Cynthia might be able to respond to, to bring it back to the children. Are there any data, or what is your feeling, thinking long term about this issue and realizing that attitudes may not change in a 55-year-old farmer or a corporation. What about the schools in changing attitudes long term?

Coll: If there were good health care and good education for the children, if we could at least do that, it would be tremendous. The problem I see right now is that the same attitudes that you might find, for example in a grocery store where people push their carts in front of Mexican

migrant farm workers because they believe the migrant workers should wait, you might find in the teachers. That is a problem, because teachers have a tremendous power over children. Right now I am working on teacher training. I do the same presentations that I have done here with teachers in national and regional conferences and I present the same data. I ask, "What are the implications of this?" My sense is that probably half of the people that come to the talk can relate to what I'm saying and the other half cannot because they only see children and families' problems and do not want to address them. However, one half are very interested in knowing how to do it. That is where we need researchers to move. We need to ask, "What do we do with the information that children are trying to make sense of their skin color, are battling it out in the playground, and that some teachers are giving up on children at the age of 6?"

There are many models right now focusing on how to work with parents. We have in our department, for example, a couple of centers dedicated to the professional development of teachers who work with cultural minorities, with ESL-teachers, bilingual teachers, and also regular teachers. We are not going to change everybody, but I say if you change one first grade teacher for the next 10 years, and she treats 2,000 children a little better, then that is something. We cannot change the whole system, but teachers have a tremendous impact, as well as health care workers and other people. We need to figure out who the people are that are closest to the children. Those are the ones that I would invest in to try to change attitudes.

Kith and Kin Care: Perspectives on Informal Child Care

CHAIR: Toni Porter
DISCUSSANTS: Sharon Lynn Kagan, Rachelle M. Tyler
PRESENTERS: Toni Porter, Ann M. Collins

Toni Porter: We are going to start by talking briefly about the nature of our work. Then we are going to talk about kith and kin caregivers in the context of definitions of informal care. I will spend a little time talking about who uses it and why, and then who provides it and why, what their issues are, what their interests are, and what their needs are.

I am the Director of the Center for Family Support at Bank Street College of Education. We are currently engaged in a variety of activities. One of them is supporting kith and kin caregivers. Also with us is Lynn Kagan from the Bush Center at Yale University, Rochelle Tyler, a pediatrician at UCLA, and Ann Collins from the National Center for Children in Poverty.

Ann Collins: We are excited to be here because we think this is such an important issue. The National Center for Children in Poverty has a mission to identify strategies to improve the life chances of young children in families living in poverty and to identify strategies to reduce the numbers of children in poverty.

I work on child care issues for the organization. It has long been recognized by us that many low-income children are cared for at some point in their lives by license-exempt family child care providers, that is, relatives, family friends, and neighbors. We needed to think about those children, what they needed, what they were getting, and how we could reach out to them.

Porter: We are all pleased to be at Head Start's Fourth National Research Conference working on these issues with people who have been focused on the needs of children and families. Ann and I are going to interweave the research she has done with the research I am doing. Then Ann is going to present some of the findings from her research on new approaches for working with family, friends, and neighbors who care for other people's children. I am going to talk about the work we are doing at Bank Street, specifically with caregivers in the South Bronx in New York.

Let me start by saying briefly that about a year and a half ago, largely as a result of welfare reform, we became very interested in the notion of kith and kin caregivers because we knew that the demand for child care was rising. We developed a concept for a project that includes four components, one of which is research. We felt that it would be important to gain a better understanding of who these people are who are providing child care for children, what they look like, what their backgrounds are, what the care looks like, and what their interests and needs are.

Based on that research, we would develop a project to provide support to caregivers, in this case in the South Bronx, but the notion is that the research should drive whatever kinds of services we provide for people who are caring for other people's children.

Collins: The National Center for Children in Poverty became interested in this issue in the early 1990s with Mary Lerner's work on exploring family child care networks in low-income communities and came to understand that we are talking about caregiving that is not on the map in many people's minds.

Since then, in October 1996, we convened a group of people from child care, family support, and community development to try to explore what we knew about these forms of care, what needed to be learned, and how we could give people some guidance. We do not have much understanding of the care and there are only a handful of studies that have looked at this in any significant way. However, families who are using it every day, policy makers involved in welfare and child care policy and practitioners have to figure out what to do on a daily basis.

Right now we have been working to assess what the current research says. We have not been doing direct research. We have been looking at models of programs.

We are working with Abt Associates on a national study of child care for low-income families which is a 5-year study to focus, first, on how state and federal policies are being implemented on the local level in 25 communities, and second, and equally important, on license-exempt child care to have some interviews with parents and providers to follow children over the course of a couple of years and provide more nuanced information than we have now.

Before we get started, I want to clarify whom we are discussing. What I found in conversations across the country is that we get bogged down with definitional terms, and that, in fact, every state has a different licensing and regulatory policy—what is license-exempt for a family child care provider in one state is licensed in another. There may be a situation where a provider may be receiving subsidies in one state with more regulations that she has to comply with than someone who is licensed in another state.

So people come to this with preconceived notions about who we are discussing. These notions come from their own experiences, definitional issues from where they live and what is required of people to care for children in general or to receive subsidies when caring for children.

I am going to talk about the words we use. I do not think at this point we have a good term for the forms of care we are discussing. Maybe that is because they are so disparate and there are so many issues related to each form.

License-exempt child care is what people refer to as legal care operations without license from the state child care agency. It can define many different forms of care, from center care offered by a school, for instance, or their parents on the premises to relatives and nannies or to small family child care homes. Generally those cluster around fewer children, but in some states it is more than that.

Informal care is what people use loosely when they talk about large family child care homes that are not licensed. However, "informal care" is a term used rather loosely to talk about relatives in home care and small family child care homes.

The license-exempt child care that is subsidized also has regulatory requirements in many states, although those vary across the board. So we are not talking about unregulated care in definitional terms if it is getting money from the state in many places. Then we, mostly because of Gwen Morgan's work, have been talking about child care by kith and kin to refer to a special group of caregivers that are family members or who act like family members within the context of a child's life, someone's godmother, grandmother, aunt, or uncle who have a daily contact or contact beyond caregiving and a relationship with the child beyond caregiving.

This is a group of people on whom we have been trying to focus because in many places, they are the ones receiving subsidies from the state. We learned this from the research and knowledge we have about subsidy systems.

Porter: Researchers will be familiar with some of the general statistics about the use of arrangements with child care situations other than child care centers or nursery schools. However, it

occurred to me when Ann was talking that the Census Bureau does not help us sort out the situation any more clearly than anybody else because of the definitions it uses for child care situations.

According to the most recent report on child care arrangements, 49% of children under 5 years of age with working parents are in care situations other than child care centers, Head Start programs, pre-kindergarten programs, and nursery schools. Thirty percent of the children are in center-based nursery school programs. It would be helpful to have a taxonomy for center-based programs.

Another 15% are with nonrelative providers in the provider's home. The Census refers to that as family child care, small caps. It is unclear whether those are licensed family child care providers, regulated family child care providers, what people outside of the field would call babysitters, or what the intern who works for me called Mrs. Fusco, the lady down the block who takes care of children.

Another 5% are in care with nonrelatives in the child's home. So those could be nannies, au pairs, or babysitters, depending on your perspective. The 49% breaks down this way: 17% are grandmothers, 16% are fathers, and 5% are mothers, either at home or in her workplace, although it is unclear whether that includes work at home or not. Eleven percent are other relatives either in the child's home or in the relative's home.

What we tend to say to make it short is nearly one out of two children under 5 with working parents is in the care of relatives.

Collins: We also are familiar with the reasons why families use relative in-home care, such as neighbors and friends. I am going to go through this quickly to say that as far as we know, much of this care is for children who tend to be very young—infants and toddlers. The percentages go down again for preschool children, and then up for school-age children.

The scheduling needs of parents have a great deal to do with why a number of them use these forms of care. A lot of work, especially for low-income families, has nontraditional and unpredictable hours. We have heard more and more that the unpredictability of work hours seems to be more of a determinant for use of care than the fact that some of it happens on evenings and weekends. We have heard feedback from child care resource and referral agencies that that is the toughest group of people for whom to find regulated settings.

We also know that in a lot of low-income communities there is not a large availability of alternative care arrangements, especially at a price that can be afforded by low-income families. Also, there are sometimes differences in the cultural match between the licensed and regulated settings and the child's own culture and race.

There seem to be very clear reasons why families use these forms of care. Recent work has looked at parents who have used child care in all kinds of settings and found something called flexibility. It has been posited that flexibility has to come from somewhere. Some people find it in their home lives in that there is more than one parent to care for children. Some people find it in their work in that they can manage their work hours. Either they can come in 15 minutes later every day or leave 10 minutes earlier or have some control over the schedule that they have. Some people find it in their child care settings.

It has been found that families who used center-based care tended to have relatively higher flexibility in family and work obligations and low flexibility in their child care settings.

Conversely, families who used relative caregivers had low family flexibility in that oftentimes they were a single parent and had low work flexibility and high child care flexibility. That is a useful way to think about care. When you talk to people who have concerns and issues and wonder why parents are using these forms of care, that is a very helpful way to phrase and think about it.

Porter: One of the questions we had in our research was: Why do caregivers offer this care? Our research consisted of a series of six focus groups we conducted last summer in two communities in the South Bronx in New York and in one community in Cypress Hills, Brooklyn. Both are low-income communities, with large proportions of families either receiving public assistance or representing low-income, working families.

All three communities have a fairly large Latino-Hispanic population that average between 50-60%. In the case of the two South Bronx communities, there was a large proportion of families who had been homeless and had been relocated to those areas in the early 1990s.

We recruited focus group participants through community-based organizations with deep community roots. They distributed flyers, asking for people who were caring for at least one child under age 6 for at least 12 hours a week to come to a discussion; child care and refreshments would be provided but the flyer did not indicate that the participants would receive a $20 stipend.

We interviewed 15 people in the pretest and had a total of 45 caregivers in our formal focus groups. Three of the focus groups were conducted in Spanish and three were conducted in English. There were 21 participants in the English groups and 24 in the Spanish groups. The English groups consisted of African Americans for the most part, the majority of whom were American-born, although there were some West Indians. In New York the Spanish-speaking population is largely Dominican and Puerto Rican and this was reflected in our focus groups.

The caregivers in our focus groups provided care for three reasons. One, they wanted to help. The grandmothers wanted to help their daughters, sisters wanted to help their sisters, friends wanted to help their friends, and neighbors wanted to help their neighbors. They were responding to requests for help. A friend came to her friend and said, "I am going back to school. Can you take care of my child?" A brother came to a sister and said, "Both of us have to go back to work and we have a newborn. Can you take care of her?" A daughter came to her mother and said, "I want to go to school. Can you take care of my child?" It was as simple as that.

The third category were people recommended as child care providers. That is, the lady down the block who takes care of children who has a reputation in the neighborhood as the caregiver, or the woman who is taking care of children and knows someone else who is taking care of children. So there is a connection among all of these people.

We found that approximately 42% of the people we talked to were relatives, and of that group, unlike Census data, we found that most of the people were aunts rather than grandmas. We think that is meaningful. We found one cousin.

We found the second largest category was neighbors and the third largest category was friends. Of the 45 people, 5 had multiple relationships, which is a fancy way of saying a grandmother was taking care of her grandchild and the child of a neighbor. So it was just five situations.

Collins: We wanted to look at the characteristics of caregivers and see what we knew. One of the things I must preface this with is that there are a lot of quick and dirty studies. For example, the kind a subsidy agency does when they send out surveys and receive some back or when they look at specific groups of people that are rather small. So we are trying to triangulate on a whole universe of caregivers from a handful of studies. Everything I say should be understood in that context.

So we found that in general, the age range of caregivers was between 40 and 60 years old. A large percentage of them primarily had no high school degree. From five or six studies combined, researchers have reported that between 15–25% had some college. The numbers of children in care were around three, and the proportion of nights and weekends of care was from 38–67%.

Porter: What we found in our research when we talked to the women in our focus groups

confirmed the existing data drawn from about six studies. We found that the age range was from 19 to the 60s. For the most part, the older women were grandmothers and the younger women were single —not even heads of household— but young women who were living with either their own immediate family members, other relatives, or friends.

We found, although we did not ask a specific question, that most of the women in our focus groups had not gone to college and had not completed high school, although a handful had gone to college and some were still attending college. A few had had work experiences outside of the home. Forty percent were married with spouses, 40% were single heads of household with children, and 20% were living with family members or friends.

We think there is a relationship between the household status and some of our other findings.

We also found that on average there were four own children per household in the Latino households and three in the African American households. Unlike the other studies, we found that most of the caregivers in our work were caring for two or fewer children. This finding surprised us because of the mythology that kith and kin caregivers are caring for hordes of children and that was not the case. Only four of the women in our study were caring for five or more children, and those children did not come in at the same time during the day. They came in at different intervals, so more than likely there were only two or three children in the house at the same time.

Most of the children in care were under age 5. The vast majority was toddlers between about 12 months and 2 years old, and the second category were 5-year-olds. We think that has some meaning as well. There were only four infants under 1 year of age.

In terms of the experience of our caregivers, which is an important factor, most of the caregivers in our focus groups reported that they had long experience caring for children. They had begun taking care of their own siblings or family members or had been babysitting for other people in the neighborhood when they were in their teens. Some of them had actively sought information about child development from parenting classes, hospital pamphlets, and classes offered at their Head Start program. Some of them reported that they had learned about child care by volunteering in Head Start or by volunteering at their child's school. So while they may have lacked formal early childhood training, some of them had demonstrated an interest in seeking more information about child development and seeking out the company of other people providing child care.

Collins: I am going to talk about what we know about the quality of care in these settings. I have to emphasize again this is very minimal. You are probably familiar with the Galinsky study of relative and family child care providers, which came up with a finding that those who cared for one or two children were less nurturing and stimulating than caregivers who treated their work more as a business. The study used quality measures for formal child care homes to evaluate the interactions between the relatives and children in these other settings as well. They came up with the phrase "intentionality" to describe the orientation to care that leads caregivers to seek training, plan activities, adopt sound business practices, and provide higher quality care for children.

We have looked at that and have talked about it with people in the field and asked what they thought. We found the intentionality definition compelled practitioners to divide caregivers into two camps: Those who are doing it for the parent or the adult and therefore the quality of the care is probably not so good, and those who are doing it on behalf of the children. We have heard much discussion about how we need to make sure that the child care providers are more intentional.

It seems that when people looked at doing work with caregivers, this dichotomy has not necessarily borne out. Many people have talked about the fact that while people have said that, in reality, they are doing it because they were asked to provide care by the parent and they had

an interest in learning more about child development. There has been much anecdotal information about people who have been working with informal providers and have found that many of them have moved on to become licensed family child care providers.

We think it does not necessarily bear out that the quality of care or the intentions are fixed; that because someone is doing something on behalf of the parent, they are not necessarily doing it on behalf of the child as well, even if the child is related to them. There are very complicated interactions that perhaps we have missed when we have talked about intentionality and we have looked at relatives.

The other concern is the quality of the setting in terms of health and safety. Very few studies have looked at the actual settings of these homes, and many of them have been done by state subsidy agencies that have been concerned with providing funding.

There were extensive studies in Rhode Island and New Jersey. In the Rhode Island study, they found that 71% of the homes that they inspected had all six elements of child care safety necessary, such as smoke detectors and plugs on the wall sockets. When they went back 2 years later to inspect the same homes after they had complied, 90% were still in compliance with these requirements.

In the New Jersey study, they looked at relative and in-home care—remember half of the care that they looked at was in the child's own home—and found such safety problems as peeling paints, electrical outlets without caps, open windows on upper floors, and dangerous objects within the child's reach.

So there were some safety concerns. However, again one has to think about this in the context of the child's daily life. The study found that the 92% of the children observed were clean and appeared well cared for physically.

Porter: Unlike some of the studies that Ann cited, we did not do any home observations but talked to people. We asked them to tell us about a typical day. We heard a variety of responses to that question and I am going to read some of them to you:

1. "With the 20-month-old twins, we have a schedule to go to sleep, and after that I give them lunch, they watch cartoons, and they write on stuff. I give them papers or crayons. When they are young, they get in the habit of picking up a pen and they start writing on any little thing, but once you write "ABC" and say, "See if you can write that," then they start to copy that, and that is how they learn. Or you will say, "ABCD" and they will say, "ABCD."
2. "I give a 3-month-old and a 5-year-old their baths after breakfast and get them dressed. After that, I go over the ABCs and their numbers and things like that. They usually would watch Nickelodeon and then they eat lunch and take a nap. They get up, play again, get a snack and things like that until their parents come at about 6 o'clock."
3. "This is a mixed age group. They like to go the park, ride bikes, skate, and throw a ball. They will play with the dog a lot. I have coloring books. For some reason no one wants to watch TV. I have dolls and one girl will play with the dolls. Or I sit them down and read to them."
4. "I have games for a rainy day. I have videotapes. They all have their favorites, different things like Lion King. Some will play with Nintendo, Sega, and Play Station. So they are all different, doing different things."

We did not ask about safety. There is another issue that I want to raise here, and that is we asked caregivers what they liked best about watching children—that was the term that they used, watching or keeping children. They said they liked watching children grow, they liked being needed, and they liked being able to help.

The fact that they liked watching children grow resonates with what we tend to look for in

prospective child care professionals, that is, a desire to care for children, a deliberate intention. However, I do not want to use the term "intentionality" but a desire to care for children in what we think may be an aptitude for caring for children.

Another point I want to raise here is that we found relatives who are caring for children full time, five of the caregivers in our focus groups were providing child care from Monday morning until Friday evening. Also, the caregivers who were offering that care spanned the range of categories in our focus groups, that is, they were relatives as well as friends and neighbors.

Collins: In terms of information available about caregivers' interests and needs, it seems to be more of impressions than research. Those impressions are divided into two camps. One is the kith and kin caregivers who are not professionals and never will be. They are not interested in being child care professionals, and therefore they are not interested in training or those kinds of activities.

We found that with people who have been doing some of this work that, in some cases, it appears to be true. In the Rhode Island study, people emphatically said that they were not interested in any training but they were very interested in get-togethers, for instance.

The second group illustrates the reality that there are caregivers out there who want to become licensed and regulated and become child care professionals. Some people who receive subsidies felt training programs were not necessarily tailored to them, but did want to know more about child development and other issues. We have heard that in Los Angeles and Baltimore and several other places, there are some efforts underway using things like the Child and Adult Care Food Program with families who receive subsidies. One of the women I talked to about this program says she keeps looking at the list and it keeps going down, and she asked someone what is happening to these caregivers. She said we keep losing them to the formal system.

Porter: Here is where I am going to reveal our frame for looking at relatives, friends, and neighbors who provide care for other people's children. We tend to look at these caregivers as part of a continuum of care that extends from parents on the one end, to early childhood professionals like family child care providers and early childhood teachers on the other with kith and kin caregivers closer to the parenting end. So using that framework, it gives us a different kind of lens on the kinds of interests that the caregivers express.

I want to precede this by saying what issues caregivers faced in our focus groups.

One major issue was payment. Most of the caregivers in our focus groups were not receiving subsidy payments from parents. However, many of them were being paid and those who were being paid extended from relatives through neighbors. They had the same kinds of issues: "She doesn't pay me on time. She doesn't pay me the right amount. The payment doesn't cover the diapers. The payment doesn't cover carfare, (which is a big issue in New York City). The payment doesn't cover the extra food." By the way, it was always a "she."

Another issue was feeling taken advantage of. "She takes advantage of me. She comes 2 hours late without calling. She doesn't pay me on time. She doesn't provide the diapers. She assumes I am going to be there for her."

Another issue had to do with conflicts over childrearing styles. "She feeds the children the wrong things. She feeds them Fruit Loops and I like to feed them fresh fruit. She lets them watch too much TV. I don't like TV. She spoils them and I don't."

Caregivers are looking for all types of information. The ones with whom we spoke wanted information about developmental delays. They would say things such as, " I don't know what to expect from 2-year olds." Or, "I have a child who isn't talking, I don't know what to do about it." They also wanted information about health. They said, "I want to know what to do with a child who is sick." Also of interest was nutrition. They wanted to know what to do about adequate and appropriate feeding when children are not eating. They wanted information on first aid,

jobs in child care, how to get a license, public assistance, and immigration. They wanted materials, books, and educational toys. They wanted to know about working with parents and how to resolve some of the issues that they had.

Collins: So the question we are really focusing on is: What are the responses to some of these issues and others by policy makers, practitioners, people involved in family support and in prekindergarten and early childhood centers, as well as informal family child care networks and so forth?

We have explored these issues over the last couple of years. We have been hard pressed to find situations where people have intentionally reached out to licensed-exempt family child care providers. However, in the last 6 months we realized a change. In part, my impression is that people who are working in the child care policy area were looking at this and were concerned about it. Then the Welfare Reform Act came along and there had to be a whole new systems rethinking, with some concern that many families were going to be using this form of care, and that it was important to focus on getting the payment systems together. People have begun to turn back to this now that things have stabilized, and things have not occurred the way they might have been predicted with the welfare reform in the first couple of years of its implementation as people had to go off the waiting list. There has not been a huge cry in many communities for subsidies the way people anticipated. Now there is some focus and a few more resources. So what is happening?

In terms of child care subsidy and policy makers, we are seeing approaches that are still concerned with health and safety of settings and what a state's responsibility is if, in fact, states are paying for care in an unregulated environment. This has two parts. One is what should be regulated. What is the number of children in a child care home that should require it to be licensed? We have seen that more and more states have been clustering around three or fewer children. However, there is a big variation around that. Once regulated, what should be required of them? What should one expect of a small family child care home?

The second part then is a question: What type of care should be legally paid for by subsidies? Should we pay for in-home care? There is a lot of discomfort with that in many places. If it is an unregulated provider or if it is a relative, should we pay for that? Are we monetizing a relationship that would happen anyway? What should be required of those providers who receive subsidies? Should there be something beyond the baseline regulations in the state? States vary widely on these issues.

In some places, a criminal background check is necessary in order to receive subsidies and in other places it is not. In some places, a home inspection and 15 hours of training is required to receive subsidies, where in some places this training is not required to be licensed as a family child care provider.

The other thing that has happened is that we have seen child care resource and referral agencies, Head Start programs, and others be successful moving people into the child care profession. That has been occurring in some places very successfully.

We were looking at highlighting some new approaches that recognize the continuum Toni talked about where they wanted to reach out and bolster caregivers who were providing care even though they were not licensed and regulated, yet did not want to encourage or grow this part of the market.

The attention that we were looking for is not people who are trying to recruit more people to be unlicensed but reach out to those people who were already doing this, people who already had relationships with children to help strengthen and nurture them. We were looking for different kinds of approaches and I am going to tell you about a few.

Rural issues are very big. In some places there just is not a licensed, regulated supply of caregivers at all. So it is very interesting to be in meetings and talk with people who wonder why this is an issue. We were looking for some center-based approaches because one of the things we

have heard is that it is an interesting model of a center serving as a hub for a lot of care giving. We found something occurring in rural Kansas where the center had a lot of educational opportunities offered everyone in the area. About half of the people who took advantage of them were licensed and unlicensed child care providers.

We looked for partnerships between foundations. In Minnesota, the McKnight Foundation has a partnership called the Minnesota Welfare to Work Partnership that is a 2-year, $20-million effort to encourage cooperative solutions to the challenges posed by welfare reform in Minnesota. One of the initiative efforts is to encourage child care resource and referral agencies and others to work with people in their communities to understand what the child care needs are. This is one of the strategies that people use to address welfare and child care needs. They include encouraging community-based solutions and being very open about what the communities should do.

In Minneapolis, there is a project that has been underway for some time called Building Better Villages. They have two models. One is where they work with a family resource center and they have a family resource worker who engages and works with parents and providers in the community. The other is a community organizing approach where they have gone out to caregivers throughout the community, both licensed and unlicensed, to ask what the community issues seem to be.

One of the community issues raised was the effect of violence on families and children in that community. Another community issue was providing culturally relevant care. So they have organized forums and workshops in conjunction with providers.

Porter: The Child Care and Families Support Partnership is one of the programs that is described in Ann's study so I will just give you a brief overview. After we did the research, we designed a curriculum for training staff in three community-based organizations to meet the needs of caregivers. We set out to directly engage caregivers in our work. The goal was to enroll 35 caregivers over a 6-month period, 15 in each of three sites. As of last week, we had enrolled 32 caregivers, with 4 on the waiting list.

The way caregivers indicated they wanted information and support from us was through support groups, which is understandable, if you think about the continuum of care framework. In many cases, caregivers function as parents and just as parenting education groups are appealing for parents, support groups are appealing for kith and kin caregivers.

At the same time, there was a small group of people who indicated a strong interest in becoming family child care providers. We have referred them to organizations that can provide the specific training they need to become licensed as well as support them through the licensing process.

We are going to be continuing with two additional cohorts of caregivers. We have a report ready on the results of the focus groups. We will have a report ready on the effectiveness of different outreach strategies. We intend to do a report on the relationship or the impact of this kind of work supporting kith and kin caregivers and community-based organizations (CBOs) because this is a community development effort meant to enhance CBO's capacity to meet their community's child care needs.

Sharon Lynne Kagan: It is such an interesting time for those of us in the field because now, more than at any other time in our history, including 1965 when Head Start began, so much attention is focused on young children programmatically, from both research and policy perspectives.

However, these papers also show us the poignant lack of attention to kith and kin care. I want to remind everyone that the numbers in these studies are very small. This does not in any way diminish the value of the results, but when we are talking about 13 million children in out-of-home care, at least half of whom are being cared for by kith and kin, and are talking about

numbers of 45, 60, and 70, there is a real paucity of data.

I would like to share with you what I think we have learned from these studies that perhaps we did not know before.

First, some of the kith and kin providers actually see themselves as less professional than center-based providers. They actually see themselves as quasi-professionals. However, no matter how they perceive themselves, de facto they are carrying out tasks that are very similar to those of more professionalized workers in the field. We need to recognize that.

Second, they are used a great deal and their services are paid for with public dollars making them a public policy issue, one that has been removed totally from the radar screen. We also need to remember that often families prefer these services. We simply cannot forget that 48% of children are in kith and kin care.

Third, kith and kin care will continue to occupy a large if not expanding segment of the market for many reasons, including the lack of care that is being provided in formal settings during nontraditional working hours and expensive infant care. Not only is this a big issue now, but one that, if we forecast forward, is going to increase.

Fourth, we need to recognize that this form of care is often preferred and used by the poor.

Fifth, people receive gratification from helping a worker or a neighbor, from watching children grow, or from feeling useful in life. The money, though it helps, may or may not be a motivator. That fact makes it complex to understand.

There are issues that we need to address from a policy perspective.

First is giving legitimacy to kith and kin caregivers, even in light of the fact that training for them remains sparse, not required, and sometimes inaccessible. When kith and kin providers seek out the job, they need to be congratulated and supported in those efforts.

Second is that overall we are dealing with the professionalization of early care and education. This is what the movement toward licensing and credentialing is all about. Yet, at the same time, it is important to provide this informality of care along with the professionalization. The question is how do we achieve a balance? How do you professionalize without making it bureaucratized and retain some of the joys parents find using kith and kin care?

Third, should kith and kin care be regulated? How many children should be regulated? Should the space be regulated?

Fourth, regulation as it is constructed in this country right now, is a big cost center. To what degree should it be regulated? This is a question for both policy makers and the field.

Fifth, the child care community in general is not sure how to reach out to kith and kin caregivers or what their relationship is to the early care and education industry. For a long time, we have been focused on centers and then on family child care, but we have had a yin-yang relationship with kith and kin care. It is not just a matter of how to define them, but also are they a part of us or not and then what is the "us?"

Sixth, how much training are kith and kin caregivers interested in receiving? How much are they willing to participate given their limited time? In other words, how professional do they want to be, because we are obligated to respect their wishes as well.

Seventh, and this is hard to answer because we do not have good data, are kith and kin services not only preferred by parents but really better for children? Are children who are in kith and kin care receiving the benefits of continuity of service that the children in other caregiving situations are not? It behooves us to understand the understated values of kith and kin care and to acknowledge them as we are ferreting out how we do this.

There are some important new strategies that these papers point out to us that need to be examined, both from the Head Start policy perspective and from the perspective of broader policy. The first is the possibility of using center-based care or family child care networks as hubs of linkage for kith and kin. It is the satellite concept. We have talked about the satellite concept most frequently with regard to family child care, often licensed family child care. Does that represent something we should consider more informally?

Second is how one infuses quality into the kith and kin system.

Third is the relationship of other subsidized programs, like the food program, as it relates to this informal segment. The lesson to be learned is that personal relationships truly matter, if this is a preferred mode of care, if it is a cost-effective mode of care, and if it provides a kind of quality that might not be available in other forms of care, what are the policy incentives that can and should be used to let this domain of the field thrive?

Future issues for us include understanding kith and kin care as a part of the entire field and acknowledging its legitimacy. If we do not acknowledge it as a part of the field, policy makers will continue to fail to address it and it will continue to be used regardless.

Policy makers see kith and kin care as a good policy deal. Therefore, there is incentive for them to recognize and support it. We need to work collaboratively to make that happen. In addition, there is simply no question this research is lacking. Several colleagues and I have been engaged in looking at the impact of welfare reform on families. By and large, large percentages of families are using kith and kin care. Our methods for data collection and instrumentations are in need of reform and clear thought. We must give incentives to obtain research information. The government should be focusing on this, as should foundations.

We need to come to grips with some of the hard policy questions that Ann and Toni have raised, questions that relate to the viability of using increased public dollars for this segment of the market. Kith and kin care, if we are honest, poses a set of real in-your-face issues for early childhood. Why have we not attended to it? Is it that we have been myopic in understanding this field? Is it that we are nervous about what it is because we deem it somewhat remote and somewhat unknowable? There is a certain field irresponsibility, and, except for the few pioneers, the reality is we have been gun-shy.

It is time to wake up. I wonder sometimes if we just let ourselves free-think, would we ever come to a time where we would consider creating a whole system (to the degree that there could ever be a whole system created in this diverse country)? Where we would think about national family leave and a system of kith and kin care for very young children, moving into quasi-more-formalized care as children mature into more formalized center-based care settings?

We need to understand that if we expanded kith and kin care, if we created incentives for it, we would need to understand what the consequences would be for the other domains: for family child care, for center care, and for the for-profit and the non-profit world. We have not thought enough about it. Thinking about kith and kin care makes me question what this field of early care and education is. Who are we? What do we value? In the press toward professionalization, regulation, and formalization of the field, what are we doing to incorporate that segment that actually has done the job, not being fully professionalized, not being fully regulated, and not being fully formalized?

These issues challenge nothing less than our basic identity as a field. I want to thank you both as well as others in this audience for shining the light on this issue. Your research, this session, and other work like it may start an important national debate on kith and kin care.

Porter: As we proceed in this area, it is important for us to delineate purposes, expectations, and/or goals from the perspective of the parent as well as the relatives and the policy makers; they may not necessarily always intersect.

Another interesting issue is how much we want to get involved in school readiness. There apparently is some interest in getting involved in school readiness with the move to Early Head Start. What does it mean for those families in terms of regulation? Are these children going to be less prepared for school? That is an important issue to also address.

Rachelle M. Tyler: I am excited about the Head Start model and Early Head Start model of reaching out to parents. We hear across the country that Head Start programs have been challenged by the fact that so many families now have to go to work. In some places, they have done

this for some time, while in other places, it is a new thing. What does that mean for the parental involvement component? What does that mean for home visiting? I was looking for examples of centers where they go to where the child is, and maybe it is not the parent who is there at the time, but the grandparent. I have not found any programs like that. If anyone knows of situations where people are rethinking the Head Start model, thinking about reaching out to other adults who are very important in that child's life, I would love to hear about it.

At a meeting that pulled together people from family support, child care, and community development, we discovered that nobody has owned this. Each of those groups could have owned it at some point, including the child care field, but it slides somewhere in between all these domains. No one has stepped forward and said, yes, this is part of our world that we need to embrace and address. The group of people on this continuum should explore partnerships. Head Start is well positioned as a field to be a leader in those partnerships. At the end of one meeting we had, someone who had run subsidy systems in one state said she had one question related to people's discussions about their concerns or hopes about this issue. The woman said, "I just want to know, how much longer we are going to wait until we go to where the children are?"

Comment: It is important to look at child outcomes too. There is some research that shows that children who are with relative caregivers are not doing as well as children who are not.

Porter: Clearly, it would be ridiculous to generalize from 45 caregivers, and 45 caregivers in the South Bronx in particular, because they do not represent the larger world of kith and kin caregivers. Therefore, one of the unanswered questions is what do caregivers in other communities and from other cultures think about? What do they want? What are their issues? What do they need? What do the arrangements look like? I am thinking of caregivers in rural areas, Native American caregivers, Asian caregivers, caregivers who are in different kinds of settings, areas where there are single-family homes.

I would like to underscore Lynne's concern. What are the consequences of different policy decisions? What are the consequences of imposing regulation on kith and kin caregivers? In terms of fiscal policy, what are the consequences of providing support to them? If there is only a finite amount of funding, where do the dollars go? Are they put into regulation? In New York City, we are hard pressed to monitor 10% of the registered family child care homes. Are we kidding when we talk about monitoring kith and kin care? By the same token, if you are talking about providing support to kith and kin caregivers, where do you draw the line if you have limited fiscal resources?

In New York State, there is a notion that the state will provide health and safety kits for kith and kin caregivers. That sounds wonderful. One hundred and fifty dollars worth of equipment sounds fabulous. However, it is going to go to kith and kin caregivers who care for the children of TANF recipients. That makes sense, too, right? In New York City, we have a huge undocumented population. Parents who are undocumented cannot receive subsidies to take care of children. Therefore, they will not be eligible to receive any health and safety kits. Even if we find some wiggle room, how does one figure out who is documented and who is not?

Finally, it seems to me, if we focus on where the children are, then we accept the notion that every child needs a healthy and safe environment, no matter with whom or where that child might be, with a parent, grandmother, friend, or family child care provider. By the same token, everybody who cares for children—parents, grandmothers, aunts—should have some knowledge of how children develop and how to support development. If we start from that perspective, it provides us with ways to tackle the tough questions about what our field has done.

Question: What do we know about the stability of kith and kin care arrangements and also, what do we know about efforts to use the home visiting model to support kith and kin caregivers?

Porter: In our small ungeneralizable sample, we found that most of the relationships were pretty stable, that the caregivers had been caring for the children from the time that they were newborns, a couple of weeks old, until the time they were 2 or 3 years old.

Segal and Lauman and also Marcia Meyers and Neil Gilbert seemed to find that kith and kin care relationships for welfare recipients were unstable, that they broke down frequently. We did not find any evidence of that. The women with whom we spoke expressed an interest in support groups and mentioned home visiting. Here is how we interpret that. There used to be a lot of research conducted on family child care and the isolation that caregivers face. Margaret Nelson talks about that. People may have been interested in support groups because they are isolated, would like respite, and/or want information that they could learn from others. The respite and the learning from one another reflects what we know about why parents join parenting groups. Home visiting is something that represents a supplementary approach.

Collins: It is hard when you are talking about grandmothers and aunts because they are always going to be in that child's life. Therefore, we do not know to what degree they are going to be the primary caregiver in that child's life.

Also, when we talk about Head Start and pre-kindergarten programs, we know about children's primary arrangements in a lot of these large studies. We do not know about those secondary arrangements. So, while a grandmother may be primary in a child's life for the first 2 years, she might also be the person picking a child up after school or doing other things.

Thus, the way we think about continuity is challenged when we think about relatives and people who function as relatives. We have data on everyone using child care subsidies in Illinois and Maryland. We have found that relative caregiving arrangements last longer than other caregiving arrangements. Also, it appeared that families who had younger children or more children tended to use relatives and in-home care. In those states, we have to think about the continuity definition differently. The Child and Adult Care Food Program is essentially a home-visiting approach. If we are looking to public funding as a way to reach out to these providers, home inspections of nonregulated settings complicate the picture. It is a question of balance about what is appropriate and what is not.

There have been some suggestions that focusing home visiting on high-risk families, like teen parents, may be useful, by using their grandmother or other ways to provide family support.

Luzanne B. Pierce: What were your instances of children with special needs in kith and kin care, and what have you encountered generally?

Collins: Caregivers talked about children with special needs. I remember two in particular and it was in the context of: "Where can I go for help for this child and where can I go for help for the parent of the child?" In our curriculum, we developed a component on special needs.

Comment/Question: I am with the District of Columbia Public School Head Start program. I would like to speak to Ann's concern about parental involvement, which is the cornerstone of Head Start.

We serve 1700 families. It has been a major challenge to get our home visits done, but most have been completed. However, we had to be creative in order to accomplish that. Parents who are in jobs may not have vacation time or sick leave. Therefore, we have done things such as going to their jobs on lunch hours. We might even meet them at McDonald's or after work hours in their houses.

Classroom involvement has declined. At the first meeting with parents, we tell them there are things that can be done at home to help the teacher in the classroom. The teacher can send notes home as well as equipment and work materials. Parental volunteer hours can be accumulated in a variety of ways and we encourage their activity by having a huge banquet at the end of the year to celebrate their volunteerism.

My question has to do with money, directly or indirectly. Do those parents utilizing nonrelative child care treat that individual with more respect, such as paying on time, paying the correct amount, and telephoning, than those who are using relatives for child care?

Collins: In our study, we were expecting differences around money, depending on the relationship between the parent and the caregiver, and that is exactly what we found.

It raises an issue that we think needs to be addressed, having to do with family relationships. Communication is one of the ways we address conflicts in relationships. Therefore, we felt that it was important to provide people with strategies on how to communicate around your expectations of the relationship. Here is where it gets complicated. For example, let us say that Lynne is my sister and we have an issue. That can be the tip of the iceberg of something that is a far deeper issue in terms of our family relationship. However, perhaps I have the communication tools that enable me to say to Lynne:

> Can we work this out? You are going to pick up your child at 5 p.m. I am not going to be able to fine you if you are late the way a child care center program might. I am certainly not going to drop my nephews off at the police station the way some programs do if you are an hour late, but can we talk about this?

Learning how to communicate is an important tool.

Comment: That gets into a whole realm that we did not mention. Our field has thought about care and the relationship between parent and provider as a negotiated business relationship. These relationships are much more complex when one is talking about relative caregivers, neighbors, and family friends. Even when we are talking about consumer education materials and supports to parents to make child care choices and help them at times when there are child care breakdowns, we need to consider this issue.

Question: Do you have data about how caregivers spend their time with the children?

Porter: When the caregivers talked about their activities, they did not use the term curriculum, which is what early childhood people would use. They talked about what they did with the children during the day. The caregivers seemed to emphasize the ABCs. I underscored this point earlier. We thought there might be two reasons for this. One is they think that it is what is expected of caregivers.

The other is there is research indicating that low-income families in particular, place a strong emphasis on preparing their children for school. That emphasis is probably well warranted for a variety of reasons. Low-income families in some cases preferred didactic teaching methods, such as memorization, because they want their children to go to kindergarten or pre-kindergarten knowing specific things such as numbers, colors, and so forth.

No, they did not say that they provided good quality. However, there were some clear indications that people could use additional support to care for children in a way that was more developmentally appropriate.

There seems to be a growing interest in providing some support to kith and kin in the context of recruiting them as family child care providers. That is not the same thing as a professional development career ladder. However, there is a notion that kith and kin caregivers represent a pool of potential professionals.

Collins: For more information about training, career ladders, and examples of places where that has happened, I recommend you contact Wheelock College because they are the true experts.

Comment: In Missouri, we have Educare dollars and Michelle and I have been part of a project called Project Reach located in rural communities. What we are finding is an unlicensed kith and kin system. When you mentioned using centers as hubs as one way to bring them in, I think that is good. Also remember, however, that some of these rural communities do not have centrally located centers or in some cases it might be a 45-minute drive to that particular center.

Therefore, in trying to essentially institutionalize a place for these caregivers, we are finding that it is different in each community. We have one county, for example, where there is a roundtable of human service professionals and they have hired a person to help institutionalize it. In one community, it is a school system that happens to be part of the caring community. It is important to keep the center as a hub, but also to know in rural communities that it has to be much broader than that.

Question: In terms of management quality issues, is there a good measure available?
Porter: The only one that we know of in terms of a study of quality is the Galinsky study. They used measures from the Harms/Clifford scale that is designed for regulated family child care providers.

Comment: Nobody in our focus groups ever said I want training, I want support, and I want to talk to other people. Even our own language speaks about training them, but we are not. Maybe we do talk about training parents, but we are moving away from that. Maybe this is the same kind of thing.

We also have to be leery of emphasizing the distinction between informal and formal caregivers now that we are learning more about the relevance this population plays in the child care industry. I no longer use the term informal because I think it underscores a dichotomy that may be artificial. I also have heard people in meetings start to talk about "informals," that is, grandmothers, aunts, and others, and how we have to train them.

Comment: I came into this with a bias, which was that these people are family members. They have never had aspirations to be family child care providers. We should accept that. We should value them for what they do. We should build on their strengths. From my own perspective, I have learned that, in fact, that is a judgment as well. We do not have any basis for many statements about this huge population of people. There are many people who are always family members first and foremost who will never even consider going into this as a career. There also is a significant group of people that have entered the field as a result.

Therefore, I try to be more balanced than I used to be. Sometimes I think I err too much on the other side as a result.

Kagan: There is a tacit assumption underlying this discussion that we know what quality is in these settings, that we know what it takes to produce this quality, and that it should be the same as what happens in more formal settings. We need to step back and examine some of our basic assumptions, particularly when we are talking about cultural relevance, linguistic diversity, and even religious diversity. We need to go slowly and be quite cautious about the value judgments we make.

Fathers—Part I: Fathers' Involvement in Head Start

CHAIR: Lonnie R. Sherrod
DISCUSSANT: Vivian L. Gadsden
PRESENTERS: Michael E. Lamb, Robert Bradley, William S. Fillmore, Jr.

Lonnie Sherrod: Fathers are important. However, their importance has not always been recognized in research, in programs for children, or in policies for children. Today, we have four pioneers in promoting attention to fathers with us.

Our first speaker will be Dr. Michael Lamb, who is a research scientist at the National Institute of Child Health and Human Development (NICHD) and who has truly been a pioneer in research on fathers. He will summarize what we know from research about fathers in low-income families.

Our second speaker will be William Fillmore, who works with the Child Development and Family Services Head Start program in Pinellas County, Florida. He will describe for us his model program for involving fathers in Head Start.

The third speaker will be Dr. Robert Bradley, who is at the Center for Research on Teaching and Learning at the University of Arkansas. He will describe for us a large national research study examining fathers' involvement in Head Start.

The final speaker will be Vivian Gadsden, who directs the National Centers on Fathers and Families (NCOFF) at the University of Pennsylvania. She has been a pioneer in directing university attention to fathers, and her center, one of the few in the country, attempts to integrate research, programs, and policies applicable to fathers.

■ The Role of Fathers in Low-Income Families

Michael Lamb: The systematic study of father/child relationships by social scientists and psychologists began approximately 25 years ago. However, concerns about fathers and exhortations or advice to fathers obviously began much before that. Family historians such as the Plecks, Griswold, and, more recently, Coltrane have described the changes in the ways in which fathers have been portrayed, described, and advised to behave over the last 2½ centuries of life in North America.

For example, the Plecks have suggested that there are four broad waves in the literature on fatherhood, eras in which fathers' primary roles were described differently. In early colonial times, fathers were encouraged to function primarily as moral overseers within their families, functioning as the representations of religion and religious philosophy within the family and insuring that children were able to adopt and adapt those values. Starting around the time of industrialization, a shift took place with breadwinning or economic support of the family being represented as one of the primary roles of fathers. Earlier in this century, they note a shift to an emphasis on sex role models as the primary responsibility of fathers. Finally, in the last 2 or 3 decades, there has been an increasing emphasis on fathers as nurturing co-parents within the family.

In his description of the historical changes and perceptions of the father, Griswold describes a much more continuous process across the course of this century, with an increasing emphasis on companionship and a decreasing emphasis on authoritarianism. This is consistent with the story that is painted by the Plecks, but sees a more continuous rather than discontinuous process.

There are three important elements about these depictions of the changes in perceptions of

fatherhood: (a) They are, with minimal exceptions, based on the views of middle-class and upper-class individuals; (b) They are almost exclusively concerned with the lives and aspirations of White North Americans; and (c) Particularly after the colonial phase, the emphasis was primarily on urban fathers without consideration of the differences between urban, suburban, and rural fathers, and those living in other cultural circumstances.

It is remarkable that this story of how the role of the father has changed in North America is one that begins not with the first North American fathers, who were Native Americans, but rather with the colonials who moved in to occupy their land. Furthermore, this story is almost completely silent with respect to the fatherhood roles and aspirations of the African Americans who were enslaved to assist those colonials and who faced a very different array of challenges as they sought to function as fathers in this society. We know, for example, that slavery exacted a major price on fathers, as they were often separated from their families by commercial transactions. Thus, from very early on African American fathers were more likely to be separated from their families.

Because of the perseverance of racist laws in this country, industrialization had different effects on African American and White fathers. A larger majority of African American fathers in rural areas had to leave their families in search of work. Again, from the early phases of industrialization, African American families were more likely to lack male heads and fathers were more likely to be separated from their children.

It is important then to emphasize at the outset that we know very little about fatherhood in anything other than middle-class, White, urban circumstances, which have been the primary focus of our research. We have only snippets of anecdotal information that help to paint a somewhat different picture of how things may have happened in other circumstances.

Social scientists began turning their attention to fatherhood only in the last 3 decades. This shifting focus on fathers coincided with two other changes at the time. One was a change in social science methodology that led to an increasing focus on survey research methodology and efforts to obtain more representative samples. The second was a cultural phenomenon, namely the emergence of feminism with its focus on a re-examination of expectations about gender roles and responsibilities. This fed an interest in fathers and, in particular, led to a focus in the beginning of the early 1970s on fathers as nurturing, involved parents within their families. This focus, however, as pointed out in the recent critique by Blankenhorn, has continued to focus primarily on middle-class depictions of families and pay little attention to variations across the socioeconomic spectrum.

Thus, social science research has underrepresented or undersampled the lower socioeconomic stations. When studies have included or focused on low-SES families, they have painted some rather surprising pictures. First, father absence is associated with poverty and, perhaps, is one of the primary causes of poverty. So many of the studies that have looked at father involvement have necessarily focused on families in which fathers are absent, or when they have sampled families that include fathers, they have tended to sample slightly more advantaged families than the average. Notwithstanding those differences in sampling, there are very consistent associations between socioeconomic status and various measures of father involvement. If anything, there is a suggestion that fathers may become less involved as SES status rises, with one notable exception being the results from the National Longitudinal Survey of Youth. On the other hand, these large-scale and smaller-scale studies suggest that there are very few consistent and reliable associations between ethnic status and father involvement.

What are lost in these studies and circumstances are the changing realities of life within North America. The most recent census data show that nearly 40% of children in low-SES families have parents who work shifts, and nearly 25% of preschool children have parents who deliberately work opposite shifts so that fathers can be the primary care providers for their children while mothers are at work.

This suggests that there is a fairly wide-scale level of involvement of working- and lower-class

fathers, although these trends have not been well-represented within the literature. There have been some attempts to study fathers in poverty or in low-SES families. Ray and McLoyd and Griswold have evocatively and eloquently described how underemployment and unemployment bring major stresses to the family that severely and adversely affect fathers' abilities to function.

The other theme that emerges from much of the focus on unemployment is the extent to which fathering in lower-income families, perhaps to a much greater extent than in upper-income families, tends to be identified with breadwinning. Low-income fathers to a much greater extent appear to identify themselves and identify their success as fathers with breadwinning or economic support of their families. So we find a situation in which the failure to provide adequately or the inability to provide has particularly devastating effects on the parental behavior and identity of fathers in these families.

These, of course, are only suggestions from a literature that is largely built on anecdotes and descriptions of individual families. What we lack are descriptive portraits of what low-income fathers do, how they view their roles, and how those roles are viewed by others around them, particularly, but not exclusively, their partners, their own parents, and their own children.

Furthermore, because of differing cultural traditions, one would expect those models of behavior and perceptions of roles to vary greatly among different ethnic groups within society and that they would likely vary depending upon the rural or urban origin of these families.

We have a couple of interesting and evocative descriptions of fathers and mothers from the rural South suggesting that religion plays a much more important role there than it does in many other parts of the country. There is good reason to believe that religion is a particularly important component to the functioning of African American families more generally. It is exciting, therefore, for somebody who has watched the emergence of a literature on fathers over the last several years to see attention finally shifting to a focus on fathers outside the realm of affluent, White, urban Americans who have traditionally been the focus of social science.

There are a number of current studies in the field that will provide information about paternal roles, perceptions of those roles, and paternal behavior in a different group of fathers. I hope that the researchers conducting these studies will be more sensitive to the variations within and across those groups than we have been in the past.

One of the important descriptors of that changing nature of fatherhood and the diverse faces of fatherhood is the Early Head Start project, which Robert Bradley will describe later. I think it is an important study because it promises to gather information about fathers and, perhaps of special importance to this audience, to look at ways in which our social institutions, represented by Head Start and Early Head Start, have treated or ignored fathers in the past. It will also explore models by which fathers could be drawn into greater and closer involvement with their children.

■ Accepting the Leadership Challenge

William Fillmore: I am going to describe a project that is very close to my heart. As a Head Start director for more than 20 years, I had always seen men bringing their wives to meetings and staying in the car. I had also seen them dodge teachers because they did not feel it was their responsibility to talk to them about their children. I began to wonder what we could do to bring these men in. I would go out to the car and ask them to come in, saying that they were part of this since these were their children and that fathers needed to be in there. There was no organized way that I knew to do this.

In 1994, a visionary in our regional office, Gwen Johnson, in her wisdom began to talk with certain male directors about the development of a fatherhood program. We talked about how we could get it funded and how we could get staff and community involvement in the program. We sat down as a team and talked about how we could partnership and develop a fatherhood

program within our region. There were 22 programs funded at that time, and every program came with a different model. Most had men volunteering in the classroom and doing activities outside the classroom, such as athletic activities with the children and those kind of activities that would really influence the family by having the man participate in them.

This type of approach, however, did not meet my needs. So, I met with some of my staff and we came up with the Accepting the Leadership Challenge. The mission of the program is to increase the participation of fathers and other significant males in Head Start with projects, programs, and activities designed to increase male resiliency.

We thought long and hard because there were many single-family homes without fathers in the community. We needed to think about how we were going to enhance the lives of children by looking at a male partnership with these families, which meant involving the boyfriend, the grandfather, or whomever the significant male was in the life of the child. This concept was accepted, and we are beginning to extend it into other programs. We are changing from calling the male participant the father to the significant other.

One thing that can either make you or break you in terms of providing a successful program is the up-front management decisions. My first decision was to partner with another Head Start program in our area: Hillsborough County. I felt this would give the men more exposure in terms of crossing the water, going to meetings, and Hillsborough's men crossing the water and coming to us for meetings. I sat down with that group, and we organized the steering committee. In our first attempt to get the community involved, we invited outstanding men in the community to a luncheon and told them we were going to organize a male project and wanted their input. To my surprise, their response was very negative. They were not supportive because they did not feel like the men with whom we were planning to work could be enhanced in any way.

Nonetheless, we continued putting together the project. We tried to get an advisory group, but it did not work. We then met with the Alpha Phi Alpha fraternity members, who were interested in working with us and who helped us design our program. Then we moved forward to do recruitment.

If a project is going to be successful, the entire staff needs to support it. Just one negative word from a staff member to a participant could cause him not to come back. Staff has to understand the program, be able to articulate that understanding, and be able to support the mission of the program.

This program meets Head Start needs because we are responsible for making life better for the children in the program. Certainly, what else does a program of enhancing male leadership in the family do but enhance the lives of children of the fathers in that program?

There is no set way to do outreach, particularly with men. One successful way I have found is to work with the women in their lives to get them excited about it. We describe to the women the kinds of things that we are going to do with the men in the program. We also tell them that we are going to tell the men how important it is for them to take turns in doing things for the child, such as preparing meals in the home, so that the women can have some relaxation time. Hearing this, she is going to bring that man there by his ear! This, in my estimation, was one of the most outstanding ways to get the men to participate.

We made sure that every time a man came into the center, he was told about the male project and encouraged to participate. We also told the children about it, because that is another good way to bring the man of the household into the program. We would say, "Would you like to see your father (or the male figure) come to a meeting and learn things?" That was an effective way of doing it. We put articles in the newspapers and went to churches, because a lot of the people in the community attended church. Word spreads out of church and is carried into the community. It is very important that one starts early to try to recruit the men.

Our program is not a full-year program. We are on the regular school system's calendar, which begins in August. We start recruitment of new families in May or earlier and the recruit-

ment of the men at the same time. We have meetings where we invite potential families to come in and, at that time, we tell them about the Accepting the Leadership Challenge program. That is very helpful. We have since developed other strategies as a result of the implementation of this program in 1994, and I will tell you about that later as one of the results of this program.

I would now like to go over the program structure. After we go through the process of trying to get the men to come into the center, we send those men who have agreed to participate out to talk with other men in the community. We have them fill out an application for the program. After they fill out the basic information, such as name, address, and so forth, there is a question that asks, "What are your current personal goals?" The next question asks, "What would you like to see yourself or your family doing in 5 years?" Another extremely important question is "What was your relationship with your father?" That is important because on many occasions we find that there was no father in the home. As a rule in Head Start, we find that child abuse and neglect comes because there was child abuse and neglect in the parents' families. We also find that fathers do not participate because their father did not participate in family activities. We use that information to help us to develop individual plans for participants. We also ask whether they would prefer to meet once a month on a Saturday from 9:00 a.m. to 3:30 p.m., twice a month evenings, or another time. That is important because if one expects them to be there, it has to be at a time they have agreed is convenient for them.

The next question is "I am interested in learning about..." They are given a list of things such as: GED programs, stress management, college, goal-setting, substance abuse prevention, budgeting, and getting a job. They either check yes or no. We find many of our fathers or significant others are not working for various reasons, and we also use that information. After that, we have a statement that reads, "If I am selected, I agree that I will attend the weekend retreat and each workshop," which they then sign and date.

After selecting men we feel we can work with or men we feel are truly interested in the program, we schedule a one-on-one interview with each man to go over the application and find out if they are really interested in participating.

In December of each year, we have an orientation in which we go over the entire program so that they will understand exactly what is expected of them and what they will be doing as a participant in this program. We ask them to bring their wives with them so we can talk about all the activities that will cause the men to be away from home so the wives are aware of this and can provide support.

In January, we have the opening session, which is a bonding retreat. We take the men out of their geographical area for 1½ days and bring in a consultant who spends time with the men doing bonding and teamwork activities. The men share information about themselves. They talk very openly, and there is not a dry eye in the place because of some of the experiences that they actually share with one another. They also do projects together.

It is very interesting to see the men come in that first day, not knowing one another, not even talking to one another, and not moving out of their space, and then see what happens to them when they get on the bus to return home. When they leave, they are jolly and talking with one another. They have made friends and have taken addresses and phone numbers so that they can call one another. They share their experiences with and provide support to each other. It is amazing what happens during that bonding session. I have even been asked by some men not to let anybody else in their group because they have not bonded with them.

The first workshop after the bonding session is goal-setting, that is, goal-setting for themselves as well as goal-setting for their family. The next activity is an all-day workshop on marriage and interpersonal relationships. Again, it is amazing the kinds of things that they share with each other.

We also include child development and guidance. We even bring in people that can talk about brain research and the things that men should not do with children. For example, we let them know that while some may think it is a manly thing to throw children up in the air, we ask

them not to and explain why. They find it quite interesting to know the kinds of things that they should not do.

We also discuss substance abuse awareness and control. We do that because we find that most of them have been exposed to substance abuse, and this workshop is extremely helpful to them. Another topic is health and nutrition. The men cook a meal, and we all eat it. This is where we talk about taking turns at home cooking so that their wives can be relieved. We also have a workshop on employment readiness since a lot of the men are unemployed and have not learned how to sell themselves. We also cover literacy and college readiness. From day one, we try to encourage them to better their education.

■ The Involvement of Fathers in Early Head Start

Robert Bradley: I would like to say how pleased I am to be here to give you an understanding of what an exciting new adventure the study of fathers in Early Head Start is for us.

I would like to start by saying that I think there is a lot that we will not do, as Michael Lamb has suggested, about men as parents. A lot of what we think we know about men as parents is based on stereotypes. It is based on limited and oftentimes very atypical experiences that we have had, media images, and a lot of secondhand stories.

As William Fillmore illustrated very nicely, sometimes what we think we know about men as fathers is based on rather peculiar encounters with men in strange circumstances. A lot of what we think we know is not based very soundly on information about the real lives of men and does not give a full and complete story. There is some good research on men as parents, but there is much we do not yet know about male parenting. It may surprise you, but I think there are now approximately 2–3 million men who are functioning as single parents in this country.

However, there is a lot about male involvement in the lives of children that we do not know, such as what male involvement means for men themselves, what it means for their children, or what it means for their partners in parenting. Recently, the welfare reform movement has regalvanized our attention to fatherhood, and there is a declared interest in knowing more about fathers. It really is, as Lamb said, part of a renewed broader cultural interest in fathers.

As far as Early Head Start is concerned, I can honestly say that we did not start out with a primary goal of studying fathers or father participation in the programs, but rather it started out as a small topic of interest. That interest grew very quickly, however, and there is now considerable interest in fathers throughout our network of Early Head Start researchers and program directors. As Lamb has said, most of what we know about men as parents comes from White, mostly urban, middle-class males. We still know very little about low-income fathers and fathers of color. So this is a frontier time for Early Head Start. We are just beginning to understand how we might productively involve men in Early Head Start and in their children's lives. Although there is still a lot we do not know about what that might mean for the men themselves, for their children, and for family life in general, we stand on the precipice of a great opportunity.

I would like to briefly tell you about Early Head Start because some of you may not be as familiar with it as you are about Head Start. Early Head Start has grown very rapidly. It has been in existence for 3–4 years and has moved from about 40-50 initial programs to what is going to be hundreds of programs across this country.

In the first wave of programs, we initiated a partnership between local Head Start programs and universities in 16 sites across the US. We paired universities and local Head Start programs into a research network that is part of a national evaluation for Early Head Start. These are very diverse settings with very diverse kinds of programs. In addition to these local programs and the universities, ACYF and Mathematica are directly involved in the studies that I am going to describe.

While our interest in studying fathers grew, we realized quickly that it would do us a lot of good if we could engage some other partners in the enterprise. We have been fortunate and successful in engaging the National Institute of Child Health and Human Development (NICHD) and the Ford Foundation, because both of those agencies already had a very keen interest in fathers and they are working with us hand-in-glove on the studies that I will be discussing.

The first question is why do we want to study fathers? The reason we are studying fathers really has two sources. The first source—and I think this is really important—is that Head Start itself has traditionally wanted to support families, which means clearly that we need to involve parents, both fathers and mothers, in the lives of their children and in the program. This is the philosophical basis. Head Start's mission is directly related to the reason that we want to study fathers.

However, more particularly, we did a survey at the 16 Early Head Start sites that are part of the national research network. The survey showed that there was some degree of priority about fathers and father involvement in the programs. One of the findings was that a number of programs have actually added men to their staffs. A majority of the programs have in fact designated at least one staff member to promote father involvement in the program and in the lives of their children. Most of the programs have at least, to some degree, encouraged men to be involved on policy boards and advisory councils and in other important ways in the program. There are some programs that have gone so far as to designate male-only activities as a way of engaging males effectively in the program and in the lives of children. There are certainly also those that have tried to come up with activities where males are an integral part of an overall set of family activities.

Therefore, programs are actively trying to figure out how to make adjustments in their programs to engage males and get them involved. Our survey showed us that this idea was already a priority; it just facilitated our interest in going a little bit further.

In our preliminary efforts to understand men, we conducted some focus groups with fathers in a few of our sites and learned several things early on in our preparation of a larger study. The first thing we found, which should not be surprising but is worth noting, is that many fathers are highly committed to their children and want to be more effectively involved in the lives of their children. Not surprising again, we found that fathers and mothers sometimes disagree on what the nature of that involvement might be and how men should be functioning as parents. Also, many fathers lack good support systems for their parenting role and good role models. Very much like the young boy, Juan, that Cynthia Garcia Coll described this morning, many of the men were reluctant to admit that there were any barriers to their involvement as fathers or any downsides to being a father. As we probe that more deeply, however, we may find that that is not quite the way things are. Fathers have aspirations for their children, but they do not always know how to help children realize these goals or aspirations. They often express difficulties on how to help their children handle their problems.

I would like to give you an idea of precisely what we are going to do in our study of fathers. We have developed a rather comprehensive approach to studying fathers that I hope will yield to us an array of useful information, not only about men as parents and how they are involved with their children, but how the Early Head Start programs can effectively engage these men in the lives of their children and in program activities.

Our research program has three major strands, which I am going to describe briefly. The first is a very broad observational and interview study of fathers at all 16 research sites beginning when children are age 2 and again when children are age 3.

The second strand is an observational and interview study of approximately 200 fathers of newborns. Because we are already well on the way in most of our sites to implementing the programs, we do not have as many fathers who just have newborns now. Many of the children are already almost 2 years old.

The final strand is a practitioner study, which actually has two components. One is an in-depth qualitative study of men at four different research sites, and the other is a very broad survey of our own 16 sites, as well as almost 300 Early Head Start sites nationwide, to try to find out the nature of men's involvement in program participation across the country.

Before I give you further details about these strands, I would like to describe briefly how the actual studies themselves came about and were designed.

Once we realized we wanted to study fathers more intensively, we set up a task force of researchers within the large network of the 16 university sites, Mathematica, and ACYF to come up quickly with an idea of how we should go about the process of studying fathers. What would be useful to do? How should we go about it? We fed this information back to the program sites to get their input. Then, we went back to the total network to get a preliminary design. Then, we asked experts from both NICHD and the Ford Foundation, which were interested in fathers, to join with us as partners. We met with them a couple of times before we actually forged the plans that I am going to present now.

What we decided to do is to build upon the previous kind of research on fathers and, frankly, research conducted on mothers. We have designed our studies on fathers so that they can be linked with the data that we are already gathering from mothers and children as part of our multisite study.

The first study, as I mentioned, has three strands. The most comprehensive or wide-ranging study that we are going to do will probably involve about 1,000 fathers from across these 16 Early Head Start program sites. This will involve both direct observations and in-depth interviews of fathers. That study's four primary goals are to: (a) determine how fathers affect outcomes for both mothers and children in Early Head Start programs, (b) identity both program and individual factors associated with fathers' participation in Early Head Start, (c) identify personal and contextual factors associated with fathers' involvement in their children's lives, and (d) examine cultural, regional, and demographic variations in paternal participation in Early Head Start itself and in the lives of their children.

We have a two-pronged approach to this primary study. First, we are going to actually observe the fathers interacting with their children. If we do that, we will have the largest array of videotapes of fathers interacting with their children that probably exists anywhere in the world.

We will do a 15-minute structured observation with two sets of play materials. One will involve a building task that presents a small challenge to the child and another is a free play task. We grappled with this because a lot of the information we have about parent/child interaction is with mother/child interaction. We were trying to figure out whether those same kinds of paradigms could yield useful information about fathers. We tried to rely on the mother/child interaction literature. We also felt we needed to make some adjustments to get good data from fathers, because what might yield very useful information about parenting from mothers might not quite yield the same kind of information from fathers.

Some of the dimensions we are going to be looking at are how responsive the fathers are, such as the level of quality of assistance they provide the child in these tasks and whether or not they respect the child's autonomy. We do know that fathers tend to play differently with their children than mothers. In our field testing of these procedures, this has been quite interesting to observe.

Those who have been collecting some of the preliminary data have found that in some ways it is often challenging and even more interesting to watch the fathers engage the children than the mothers. There is a different character of interaction. We are going to learn a lot from this, especially when we have information on 1,000 fathers.

The second thing we are going to do is to subject the men to a structured interview. In addition to the structured part of the interview, we have five or six open-ended questions that are more qualitative in nature. We are trying to build in different kinds of data collection

procedures. I can tell you from our site in Arkansas that the fathers sometimes go on and on in providing us information with the open-ended questions.

We are trying to understand men's lives and the factors that affect their involvement with their children and with the program. We want to know what fathering means to these men. What kind of factors really influence how they parent? What do they think is important for their children? How do they see their role?

We will get basic demographic information, such as the men's employment history, as well as information on the amount and kinds of time fathers spend with children. What do they do when they are engaged with their children? We are concerned about their ideas about discipline, about child care, and about the role of the father. We are concerned because what fathers do as parents, and the literature shows this already, is closely related to their broader network of relationships, such as their relationships with their own fathers, their own parents, and their partner. The men's health status, including their mental health status, is another important piece of information that we want since that could certainly contribute to their involvement in the Head Start program and their involvement with their children.

The second strand is our study of fathers of newborns. One of the nice things that happened when Lamb and the others joined with us as partners is that we were able to step back a little. We were already moving along in our 16 sites, and most of our children are well into their second year of life. However, we felt it was important to understand fatherhood from the beginning of the fatherhood process because when one looks at the father-child relationship when the child is age 2 or 3, that relationship has already been built over some period of time. It is important to have information about fathers' roles, their interactions with their children, and their influences during the newborn period.

The goals of this study were to: (a) examine fathers' roles, interactions, and influences on children and family from the time of birth, and (b) examine the influence of Early Head Start programs and relationships with children and families. This is a longer-term view that we will have with approximately 200 fathers who are very diverse in terms of ethnicity, region, and community of origin. There are men from both rural and urban communities. In a somewhat similar fashion to what we are doing for the larger study at ages 2 and 3, we are going to engage in qualitative examinations, structured interviews, and some observations.

The final strand is what we call the practitioner study, which has different goals. Its primary goal is to examine the strategies used by Early Head Start programs to engage fathers. We heard a wonderful description of what one Head Start program is doing to engage fathers, but we want to know what Early Head Start programs across the country are doing.

A second goal is to learn about the fit between the program strategies and what fathers state are their needs and preferences in terms of activities and so forth. Another goal is to figure out what the barriers are that programs encounter in successfully engaging fathers. Again, we had a good description of the difficulties that Fillmore has faced in Florida. We are trying to figure out how best to make male involvement happen.

Finally, the study's fourth goal is to track how programs change over a period of time to try to be more responsive. If they make attempts early on that do not work, how do they change to try to successfully engage fathers?

We are going to use, as I mentioned earlier, a two-pronged approach. We will carry out very in-depth qualitative studies of fathers at four different research sites. We have some expert qualitative researchers who will conduct a series of in-depth interviews, focus groups, and other kinds of qualitative techniques. The other prong is a very broad survey that we will conduct across the entire country at nearly 300 current Early Head Start sites.

So that, briefly, is what we are doing to study fathers. I think, as I mentioned earlier, we are on a frontier here. At the same time, because we have the opportunity to go into such a diverse array of households, include such a diverse array of the community, and utilize such a diversity

of program kind of approaches, I hope that in about 2-3 years from now we can actually inform the literature in a rather profound way about what fatherhood means, particularly to low-income men and men of color, what contributes to their involvement in the lives of their children, what enables them to be engaged by programs, and ultimately what that means to them, their children, and the rest of the family.

Vivian Gadsden: The title of this year's meeting, "Children and Families in an Era of Rapid Change: Creating a Shared Agenda for Researchers, Practitioners, and Policy Makers," is a particularly interesting and important way to enter into a conversation and, therefore, to sustain a discourse about the issues we have begun to discuss in this session.

What does it mean to have a shared agenda? I asked that because at the very outset of the National Center On Fathers and Families (NCOFF), we thought about what it meant to have a shared agenda. Who should we talk to first? Since we were all researchers, we decided to begin by talking to people who were out in the field, those who work with families and fathers every day. We identified about 60-70 practitioners around the country, conducted telephone surveys and face-to-face interviews, and asked them, "If you had an opportunity to identify the two or three major learnings from your work over the past 5, 10, and 15 years that you could share with public policy makers and researchers, what would those learnings be?" They identified 10, 7 of which were common across all groups.

The first learning is that fathers care. The second is that a father's presence matters. Third, for many fathers, unemployment and childlessness are serious impediments to their participation in family life, particularly given the emphasis throughout our history as a nation on the role of fathers as providers.

The fourth had to do with the inherent barriers in the system to fathers becoming involved that seem extremely difficult to overcome and therefore mitigate against. Usually these had to do with child support and paternity establishment. Even though many of the practitioners as well as the fathers thought paternity establishment was important, there was a lot of misinformation about what it would mean to claim paternity for a child. Once paternity is claimed, one has to pay child support, and there were mixed feelings about child support. Not only or necessarily that it was unimportant to pay child support, but that it was not clear how much of the funds would go to the child and because of the ramifications of saying publicly that one is a father and has to contribute child support but not have a job.

The fifth had to do with cooperative parenting. Until recently, cooperative parenting focused primarily on divorced parents—people who sometimes used the child as a bargaining chip. We had two purposes here. First, we had to think about how to remove the child as a bargaining chip and reinject the child as a treasured person. Second, we needed to think about the ways in which we talk about cooperative parenting with parents who have never been married.

If one looks at the big picture, we can say that it worked with at least a fairly large percentage of the participants. However, there was a range of things that we needed to understand to be able to create cooperative parenting programs. The Ford Foundation is about to do some work to support what they are calling peer parenting, which is really just a new lexicon for this work.

Cooperative parenting made some assumptions about the ways in which two parents, irrespective of how they got to be parents, came to appreciate and value the life course development of children and the well-being of children. It had them think about what they had to contribute, not only from their financial possessions, but from their emotional possessions. What was it that they were willing to give up, in order for these children to survive and to thrive?

A sixth had to do with role transitions. I have always believed that very often parenthood has become a proxy term for adulthood. When people become parents we suddenly expect them to develop all of the perfect responsible behaviors. Adolescent girls and boys do not do that. Sometimes 30-year-old boys and girls do not do it. When an adolescent has a child, we expect him or her to take the responsibility, but we are stunned when they are not willing to do that. So

what we were interested in looking at is not adolescence, but rather what the niches are and what the points are over the life course that allow people to first develop the strengths, abilities, and thoughts about parenthood that allow them to engage both emotionally and financially with their children. What other kinds of supports are necessary in order to make those developmental markers more significant?

The last learning had to do with intergenerational learning. We were interested in what happens with families of origin. What were young parents learning from their own fathers and mothers? What about those learnings came to be a part of the family folklore? They had to do with the family culture.

What did parents bring from their own families? Were their fathers were present or absent? How did they conceptualize parenting—fatherhood and motherhood, and how do they act on that? Of course implicit in this core learning is a need for longitudinal study. When we talk about the fathers in the programs, it is important to find out about what their own fathers and grandfathers contributed. It is also going to be very important for us to look at what happens to the children of the families who are currently the focus of our efforts and compared to other children.

We see these core learnings not as facts, but rather as a framework in which to begin to study the field more broadly. We do not believe that they are ultimate truths, but rather they are hypotheses that allow us to go into the research studies and determine the degree to which they cohere with what the practitioners have done.

There was a reason that we wanted to do this. We wanted to create a strong mutual relationship between researchers and practitioners. These are the two critical domains of effort. If we could get those two groups of people to talk and to have a real community together, then they could make some impact or make some contributions to the formulation of policy.

There are a few things that need to be considered at this point. The first is that we need to think more broadly about what is not covered. In order to get an idea of what existed within those core learnings, we decided to create a database called the National NCOFF Father-Led Research Database. We have approximately 8,000 articles whose abstracts have been rewritten and indexed. One can go into a number of smaller libraries and identify any number of articles on a selected topic. It looks a lot like the ERIC database and is available on our website. We also created something called the Father and Family Link, which is updated daily. That website is both a sub-forum in the Children, Youth and Families Forum for Handsnet as well as a separate forum on the Internet. It contains not only NCOFF's materials, but also materials that come to us from around the country.

I want to tell you about how we have translated and used these core learnings to continue the rest of our work. The first is the creation of a series of research teams that are intended to develop the core learnings and other issues in the field. We first interviewed the practitioners in 1994 and again 1½ years ago and asked them what they thought was important. They identified several different areas of work. I am going to tell you about the seven areas that the Family Development Research Group will focus on.

One issue that cut across all the discussions was the role of fathers and research discourses and the ways in which these research discourses intersect with the popular press. Sometimes there is a disconnect between what we are saying in these research communities and what is being described in the media. The media talks about father involvement and father engagement in a way that suggests we should be highly involved. What the media does not talk about, and to some degree what we as researchers do not talk about, is the complexity of getting fathers engaged and sustaining their engagement in playing out the broad range of issues that have to do with father presence.

Nor are we dealing very seriously with the degree to which a focus on fathers, as it has been constructed in many different places—particularly by the popular press—works against or is a backlash against mothers.

Gender issues or studies of gender have not been as broadly defined as they should have been. Gender to me means two, at least. So if we were really doing work on gender, perhaps this issue about a backlash would not exist.

There is some concern, however, about the degree to which studying fathers somehow becomes an easygoing, "whatever time is convenient for them" process versus an historical, much more cryptic, much more rigorous approach to the ways in which mothers are studied.

What we aim to do is look at those more difficult and complex issues. Michael Lamb has been looking at those harder issues for some time. We need to continue that and not have two streams of work: an isolated stream of work on fathers on one side and work on the families in which mothers are inserted on the other. Our goal is to bring together one area of family studies and then look more critically at the range of issues that need to be discussed in order for children to survive and be healthy.

The seven research teams focus on fathers and fatherhood, particularly with an emphasis on state policy and welfare reform. We started about a year ago having a series of state policy meetings with governors and state departments interested in doing more work around fathers. We were very interested to see, and we certainly saw it in many different ways, that there was very little understanding or preparation to focus on fathers. There was a document that was published by the National Center for Children in Poverty (NCCP) along with NCOFF and the Council of Governors' Policy Advisors (CGPA), called "Map and Track: State Initiatives to Encourage Responsible Fatherhood," in which they looked at what was happening at the state level to involve fathers. While the federal effort is important, what is going on in states is critical and is significant over the long-term.

A second research team is focusing on conceptualizations of fatherhood and the relationship of these conceptualizations and the construct of fatherhood to family processes. What is happening to children in urban areas versus rural areas? How does the reinsertion of a father or the initial insertion of a father somehow redefine family processes?

A third has to do with child well-being in the home, school, and community contexts. A greater emphasis is placed on the transitions, for instance, from Early Head Start to Head Start to school. What is happening within communities, particularly around schools in communities? We are currently involved in a project near the University of Pennsylvania, in a community called Manchua, in which the core of the research project focuses on fathers. What they are interested in doing, however, is something more than looking at fathers. They are interested in looking at fathers as separate from families, within the context of families, and within the context of schools and communities. To be able to do that, they believe that they need a number of partners. They expect that the result of their efforts will be some community transformation that will discourage people from moving from that community because they will have a strong enough community that they will want to stay and work on these issues.

Many of the fathers in the study have had extremely difficult relationships in schools. We are not only talking about learning to read, but also about the gamut of skills and abilities that fathers need in order to be able to get work, sustain work, and contribute to their children's development, both in school development as well as psychosocial development over time.

A fourth group has to do with family structure and development. Threaded throughout those discussions are issues that have to do with culture and culture separate from race. It also has to do with race and the mitigating factors of race in family structure. Then there are the issues of class and poverty.

There is also a group that has to do with intergenerational learning and life course development. It focuses broadly on longitudinal work that we would like to do with fathers. We would like to see what happens to the children in programs over time.

The last group looks at issues of poverty and social vulnerability, within which we have collapsed a lot of things that were told to us by both practitioners and fathers over the past year. This to me is one of the most important areas of work that will be conducted because poor

fathers and poor families are still outside of the realm of the work that we do. Even though we work with poor families, the chronically poor, the intergenerational poor have yet to be looked at in a serious way. This is poverty both within urban and rural settings. We know a little bit more about what happens to poor people in urban settings, but what happens to poor children in rural settings is somehow still outside the circle.

When one talks to the practitioners about these issues one is supposed to be talking about the fathers. However, it is not about the fathers at all. The fathers are strewn as examples here and there, but people really are talking about their own experiences and the ways in which they grappled with the issues of fatherhood and family. What was striking to me was this reference to vulnerability and a sense of alienation and not belonging, particularly for young fathers whose families had been intergenerationally poor. There was a lack of knowledge about how one could do things differently. How does one make it in the world when one does not have examples of how to do it?

It is not about simply getting a job, but keeping a job. How does one not get so angry with one's employer that one does not use an expletive and walk out the door and therefore not be able to come back in? How does one negotiate life and figure out what one's resources are? If one were to ask me what the biggest challenge is in fathers' programs, I would say that it is this—helping them figure things out over the course of their life. No program should look the way that most programs look today, but it may be possible for us to use this point to reconstruct and reconceptualize what it means to support families in general.

Is there a way for us to think broadly about how we are going to support fathers, particularly those who have the most complex lives and have lived under the most difficult circumstances? How do we give them the kind of support they need, which would, by necessity, be intensive in the beginning? What do we do later on in the second, third, and fourth years? How do we engage communities in a specific kind of effort that insures this kind of work begins to happen?

Two other pieces of work we are doing I hope will figure into this. One is a greater emphasis on practitioners. We are also doing a study of practice and practitioners, which we have been trying to get started for the past year through a survey. It is a conversation we need to have. We have identified more than 1,000 programs around the country that serve fathers in some way, and they typically exclude the Head Start and Early Head Start programs. What we would like to do, however, above and beyond collecting those data, is some in-depth work at selected sites so that we can have an ethnography of practice and programs. In this way, we can get some sense of what goes on in the program, but we also can get some sense of what it means to be a practitioner running those programs.

We need to look at what the interface is between those programs and the communities. What do these programs do that allow communities to grow, so that rather than having a nice project sitting in the middle of the community that everybody knows about, we can see specific kinds of changes in the community as a result of that program having been there? Are there more fathers to be found in that community? Are there different relationships with schools and teachers? Do we have stronger coordination among the multiple resources within the community? If not, how can that change?

We are taking the first steps in what will be a very long journey. As we consider that journey, I would suggest that we conceptualize broadly what our notions of fatherhood and families are, that we look at families that have different forms and different configurations, and that we do not put a generic stamp on all families. Some families are middle-class, some are poor, some are African American, and some are White. When we hear something about fathers and families, we should not immediately presume that we are only talking about low-income fathers.

At the outset of NCOFF, we had a literature that was largely about White, middle-class fathers. Yet we had programs that were only serving low-income fathers of color, so we were looking for a place to have those two entities connect. Where was the nexus? Was there some literature that could be applied? How could we rechart, rechannel, and monitor studies that would be more

integrative? I would really have us guard against having two strands of work—one that makes middle-class fathers be seen as those who are doing everything just fine, therefore we need not study them very much, and another that makes low-income fathers and families be seen as dysfunctional and not able to contribute.

There are certainly different kinds of fathers, and families have different kinds of problems. We have evidence both from studies in psychology as well as in sociology and related areas that there are some issues that run across all families. We need to be able to identify them. We need to be able to invest in the most rigorous and thoughtful research approaches to study those families who have been excluded the most from research and from policy discussions, but used the most to make a point for our political gains. I would like to really encourage you to continue this work and to involve the NCOFF.

AUDIENCE QUESTIONS AND COMMENTS

Question: Mr. Fillmore, you said you tried to involve some men who were not biological fathers. Could you tell me more about them? Who were they? Were they grandfathers? Did they live in that home with the children?

Fillmore: It was the most significant other to that family. It could be a brother, it could be a grandfather, or it could be just a neighbor, but it was someone who provided the male image to that child and support to that family.

Question: Could you give us some sense of who these individuals were or an example that would stick in my mind?

Fillmore: Last year, there was a grandfather who did not live in the home but who was the male image in the family and helped to support that family. He came, he did participate, and he did try and use what he learned with that family.

Question: Do you have men or women facilitating the program?

Fillmore: That is a good question because when we started our sessions, most members of the planning committee were women. When we do the opening session, they attend for introductions, but then they leave and come back by invitation only. We try to have male leaders for the group because when they discuss certain issues, the men would not be that open if women were present.

Question: What criteria do you use to define "father"?

Bradley: Our definition of father is actually very inclusive. We will be studying married and unmarried fathers, fathers who live in the home and fathers who live outside the home, and so forth. We have a fairly broad definition now.

As a matter of fact, based on the experience we have already had, as well as other studies that have been conducted, it is obviously a lot easier to reach those fathers who are living in residence with the children. It is also easier to get fathers who, if not living in residence, have relatively consistent contact with the child. The further one goes away from that in a practical sense, the more difficult it is to get them to participate, but we are not in any sense excluding them.

Question: Who is the initial point of contact?

Bradley: The mother is the initial point of contact. Partly because as the children typically come in to Early Head Start and go through the process, most often though not exclusively by any means, the mother is the one who brings them and serves as the primary contact. The mothers are our initial source of information about the child's father.

Question: What if the child's father is not present?

Bradley: That is why I am not saying it is only biological fathers. Generally speaking, it is going to be most often, but not exclusively, the male person who is currently most involved in the life of that child. We have tried to leave the door open so that a multiplicity of men who are potentially involved in children's lives could be part of this, but, generally speaking, it is going to be that male adult who is playing the most significant role at that point. It may be that the mother has a new partner who is not the biological father. It could be a biological father who is no longer in residence. All of those men could participate. As I said, we are not excluding anyone, and we have no specific focus that the man needs to be the biological father rather than what is sometimes called the social father.

Fathers—Part II: The Diversity of Father-Child Relationships and Implications for Head Start and Other Early Childhood Programs

CHAIR: Jay S. Fagan
DISCUSSANT: Vivian L. Gadsden
PRESENTERS: Jay S. Fagan, Brent A. McBride, Jaipaul L. Roopnarine

Society is increasingly demanding that men who bear children assume an active father role. Yet, men are often unprepared for the tasks and responsibilities of fatherhood. While some men have become highly involved in the care and socialization of their children, many men have struggled to participate even minimally in their children's lives. Furthermore, there is much diversity in men and women's definitions of good fathering or what it means to be an involved father.

Practitioners, program planners, parents, and researchers have begun to recognize the need for parent education, support, and involvement programs for fathers and other significant males. A recent national study of parent education programs revealed that 80-85% of the programs studied did not work with fathers (Carter, 1996). While there are many factors that are likely to influence program success in working with fathers, an important consideration is staff members' appreciation of the diversity of beliefs about the father role, family structures, father-child relationships, and pathways through which men become involved with and maintain relationships with their children.

The goal of the symposium was to stimulate the audience to think about the implications of this diversity for working with fathers and other males in Head Start and other early childhood programs. The first paper discusses research on Caribbean immigrant fathers' parenting styles and beliefs, support for education, and involvement in their child's early education in preschool and kindergarten. The second paper presents research findings from a father involvement intervention program for African American and Latino fathers who have children in Head Start. The third paper presents results of research on a program designed to provide a wide range of support services for staff members as they struggled to overcome the hurdles associated with encouraging fathers/men from low-income and high-risk backgrounds to become involved in early childhood programs.

Reference

Carter, N. (1996). *See how we grow: A report on the status of parenting education in the U.S.* Philadelphia, PA: The Pew Charitable Trusts.

■ Immigrant Fathers and Early Childhood Education: A Look at Caribbean Immigrants

Jaipaul L. Roopnarine

Some 24 million immigrants currently live in the U.S.; this represents the largest wave of immigration in recent history. From 1983 to 1992, there were 8.7 million new immigrants to the U.S. In 1992, approximately 44% of these came from Latin America and the Caribbean, while 29% came from Asia. A majority of the new immigrants and their young children are concentrated in five states: California, New York, Texas, Florida, and Illinois. Providing appropri-

ate education for immigrant children becomes a complex challenge when we consider the diminished financial capacity of school districts and community agencies to address issues of bilingual education, English as a second language, counseling, and other services for immigrant families and their children, as well as possible discrepancies in beliefs about early education and intervention between immigrant families and early childhood educational agencies. These issues may become even more pressing if we consider the cultural beliefs about child rearing and the roles of mothers and fathers in the early education process.

The proposed work focuses on the sociocultural context of the home environment in examining the school achievement of 40 prekindergarten and kindergarten children of English-speaking Caribbean immigrants who reside in economically depressed neighborhoods in the New York City area. Data were gathered on mothers' and fathers' parenting styles and level of investment in basic caregiving, their "ethno-theories" about education and acculturation, the manner in which they structure the home environment for achievement, sources of support for achievement, and sharing responsibility with children for schoolwork. Parents were also asked to assess their child's personality and provide estimates of their child's school performance and use of time in the home. The Kaufman Scales of Early Reading and Mathematics Skills were administered to children at the end of the school year. Analysis will focus on links between sociocultural beliefs and parenting practices and investment in structuring the home environment for achievement and children's achievement at the end of the school year.

There is every hope that a study of this nature will help us move toward a more culture-specific understanding of how factors within the sociocultural environment of the family influence children's achievement early in the schooling process. In particular, the role of Caribbean immigrant fathers in early childhood and schooling will be further delineated.

■ Father and Father-Figure Involvement in Head Start: A Quasi-Experimental Study

Jay S. Fagan

An evaluation study was conducted to examine the effects of participation in a Head Start-based father involvement intervention program for fathers, father figures, and their children. This study considered whether father involvement programming in Head Start had a demonstrable effect on: (a) the amount of fathers' involvement with children in the home environment, (b) fathers' child rearing practices (nurturing, responsiveness, positive control of child behavior), and (c) children's social and academic readiness skills. The father's level of involvement (low, adequate, or high) in the intervention and comparison Head Start programs and child gender were also considered in relation to outcomes.

The study used a quasi-experimental research design that compared pretest and posttest measures for participants in four intervention sites against nonparticipants in geographically and demographically matched comparison (control) sites. One hundred and forty-six fathers and father figures were recruited for this study. The majority of the men were African American (65.7%). A large number of fathers were Latino (27.4%). The intervention involved adapting traditional Head Start parent involvement activities for fathers and father figures. The program components included: (a) fathers volunteering in the classroom, (b) weekly Father's Day programs at each Head Start site, (c) father-sensitivity training for early childhood staff members, (d) fathers' support groups, and (e) father-child recreation activities.

The findings of this study showed that, compared to controls, fathers in the intervention program were significantly more involved with children in the home environment at posttreatment. Specifically, fathers in the intervention group engaged in more direct interaction and

support for learning with their children. There were no significant associations between involvement in the intervention and increased accessibility or giving of care.

The findings also showed that the amount of fathers' Head Start involvement was positively associated with increased paternal engagement of children in direct interaction, accessibility, and support for learning, regardless of the father's treatment group assignment. Additionally, father's direct interaction and support for learning increased significantly when adequate-involvement fathers were compared to no- or low-involvement fathers and when high-involvement fathers were compared to adequate-involvement fathers.

The results of the study, however, did not support the hypothesis that the intervention program would have a significant and positive impact on fathers' child rearing behaviors. There was also no significant association between level of Head Start involvement and child rearing behaviors. These findings seem to suggest that while the intervention program may have been associated with increased levels of positive engagement with children, there was no residual impact on fathers' actual child rearing behaviors.

Furthermore, the findings of this study did not support the hypothesis that children of fathers in the program would demonstrate improved social skills. The children of fathers who were highly involved in the program, either as controls or intervention fathers, did not show significant improvements in social skills. The results of the study partially supported the last hypothesis that children of fathers in the intervention program would show improved academic readiness skills. Specifically, the intervention group was associated with increased problem-solving skills (early mathematics readiness) among daughters, but not among sons.

■ Father/Male Involvement in Prekindergarten At-Risk Programs: An Exploratory Study

Brent A. McBride, Thomas R. Rane, Ji-Hi Bae

The purpose of this exploratory study was to examine the impact of an intervention program designed to encourage and facilitate father/male involvement in state-funded prekindergarten programs for children identified as being at risk for later school failure. In contrast to other intervention programs that provide direct services to fathers and/or families, the focus of the current intervention program was on providing support services that would allow staff members to develop the knowledge base required to successfully plan, implement, and evaluate specific initiatives to encourage father/male involvement in their programs.

Most early childhood educators have received little, if any, formalized education or training in the area of parent involvement. This is especially true in the area of father/male involvement in early childhood programs. The focus of this intervention was on providing a wide range of support services for staff members as they struggled to overcome the hurdles associated with encouraging fathers/men from low-income and high-risk backgrounds to become involved in early childhood programs (e.g., resistance to initiatives to encourage father/male involvement, preconceived biases about fathers/men and involvement with young children, training and support services for staff members in developing activities for fathers/men, helping women become facilitators of initiatives targeted at fathers/men, etc.).

Participants in the study were 21 teachers at two state-funded prekindergarten at-risk programs in neighboring Midwestern public school systems (treatment & control sites). Evaluation data were collected in 2-week segments during the 1996-97 academic year at both treatment and control sites for all initiatives involving family members. This data included detailed information about the types of parent involvement and partnership initiatives planned and imple-

mented, who initiated them, the nature and content of these initiatives, the method of the initiatives, and who participated in the initiatives. Teachers at both the treatment and control sites also completed the Attitude Towards Father/Male Involvement questionnaire and the General Attitude Towards Parent Involvement questionnaire. Analyses indicated that a significant relationship existed between teachers' attitudes towards father/male involvement and the participation rates of men in parent involvement activities across both sites. Analyses revealed significant differences in the participation rates of fathers/men in parent involvement activities, with treatment group teachers reporting a higher proportion of father/male involvement than control group teachers did.

These findings suggest the intervention program was effective in providing teachers with the skills and knowledge base needed to develop and implement initiatives designed to encourage father/male involvement in their early childhood program. Comparison of parent involvement data of the teachers within the intervention site indicated significant differences existed in the rates of father/male involvement across classrooms in this program. This finding, combined with scores from the Attitude Towards Father/Male Involvement questionnaire, indicates that the intervention program may have had a differential impact on teachers within the target program. Implications will be drawn from the findings for preservice and inservice early childhood teacher education, as well as on the utility of providing support services for early childhood educators as they struggle to identify ways to encourage father/male involvement in their programs.

Relationship of Early Brain Development and Later Development Issues: What We Know and What We Still Need To Know

CHAIR: Kathryn E. Barnard
DISCUSSANT: Jack P. Shonkoff
PRESENTERS: Michael Meaney, Charles A. Nelson, Dana E. Johnson, Robin Karr-Morse

Kathryn E. Barnard: As many of you know, there have been a number of public reports about the importance of brain development. This symposium will share an array of interpretations of the latest research findings on brain development, and discuss what we as scientists and practitioners ought to be doing about it.

Michael Meaney: I am going to summarize the highlights of research on early experience effects on brain development. We have been able to bring the principles of great scientists, such as Hebb, Erikson and Bowlby, down to the level of a cell, "cellan molecular-neofreudianism." Although that may sound absurd, I would like to convince you that there is at least a grain of merit in that notion.

First, I would like to present findings from a paper that was published in the *Journal of Behavioral Medicine* in 1996. It is a follow-up to the long-term Harvard Stress Mastery Studies that began in the late 1950s and early 1960s. In this study, a population of undergraduates was questioned about the nature of their early family relationships. The researchers defined individuals whose relationships with their parents were either cold and distant or warm and close. The small sample was followed for 35 years. The researchers found that the incidence of multiple forms of chronic illness, including alcoholism, depression, heart disease, and type II diabetes, was four times greater among those who had had cold, distant relationships with their parents by comparison to those who had had warm, close relationships. The question that we pose is why does the relationship between family quality, parental care, and health exist throughout the course of the life span?

We focused on an endocrine system known as the hypothalamic pituitary adrenal axis as a mediator. This axis produces one of the major stress hormones, the gluco-corticoids. Signals associated with stressful events cause a certain population of brain cells in the hypothalamus to release hormones known as cortico-tropine releasing factor and arginine vasopressin. These peptide hormones are released into the circulation and are fed into the pituitary. The pituitary releases a hormone known as ACTH and, thus, mobilizes the adrenal glands to produce gluco-corticoids.

During a period of stress, one's body is under a metabolic challenge. Cells in various parts of the body, notably the liver, heart, lungs, and brain, work harder and require more fuel in order to meet the metabolic energy demands of these cells. In response, the body produces stress hormones. Gluco-corticoids and catecholamines mobilize energy substrates and increase the heart rate and blood pressure. As a result, energy is better distributed to various parts of the body.

Utilization of fat and glucose reserves and increased heart rate and blood pressure during

periods of stress is absolutely essential. Unfortunately, the more frequently one mobilizes this response, the greater the risk for many forms of chronic illness. Excessive, chronic stress places one at greater risk for diabetes, heart disease, depression, and anxiety. We find that individual differences in response to stress can explain individual vulnerability to such diseases.

Our hypothesis states that individual differences in stress reactivity are in large measure determined by one's early environment. The early environment regulates the development of pituitary adrenal, as well as sympathetic responses to stress. In doing so, it can influence one's vulnerability to disease. Hence, individuals who show exaggerated pituitary adrenal responses to stress are known to be at significantly greater risk for heart disease, diabetes, alcoholism, and multiple forms of the affective disorders. This is one way that the early environment contributes to differences in vulnerability to disease states.

The quality of parental care in the early environment is probably the major determinant of individual differences in pituitary adrenal as well as sympathetic responses to stress. I am going to make the argument that naturally occurring individual differences in stress reactivity in populations of young rats and maturing rats is largely dependent on a factor known as "mom."

The regulation of the hypothalamic pituitary adrenal (HPA) response to stress depends on an entire set of neural circuits in the brain that one might think of as the software. The hypothalamus, the pituitary, and the adrenal glands are the hardware. The system is driven by the neurocircuitry. Brain regions such as the amygdala interpret a stressful event, release the corticotropin-releasing hormone, and signal the locus coeruleus brain cells to produce noradrenalin. Noradrenalin is the major hormone or neurotransmitter in the brain driving the HPA response to stress. The greater the response in certain nuclei in the amygdala, the greater the activation of these cells. Thus, more noradrenalin is released, which produces a greater HPA response and emotional response to stress.

Through many years of research, including deprivation studies, we have learned that the development of the entire neuro-circuit depends upon normal contact between a mother and her offspring. If 3 to 4 hours of separation occur between a mother rat and her offspring per day for the first 2 weeks of life, the offspring is far more reactive to stressors in its environment than had no separation occurred. Long periods of maternal separation increase the release of corticotropin-releasing hormones and noradrenalin and amplify the magnitude of the response to stress. Thus, deprived animals show more fear, anxiety, and a greater pituitary adrenal response to stressors.

Deprivation studies have identified neural targets that are sensitive to extreme forms of manipulation in early life. However, it is still unclear what aspect of the relationship between parents guides the development of these systems. While studies of extreme forms of separation in animals examine the development of vulnerability pathology and might map onto neglect in humans, they do not reveal the importance of naturally occurring variations within a normal range of parental care. I would like to suggest that such naturally occurring variations of parental care in the rat are of tremendous importance in determining individual differences in the development of multiple brain systems.

First, let us examine what comprises maternal behavior in the rat. Maternal care in the rat consists of nursing bouts. Mothers approach the nest, gather the pups underneath, and vigorously lick and groom the pups, which stimulates, arouses, and activates them, causing them to suckle. Mothers continue to lick and groom pups intermittently while they are suckling. After approximately 25 minutes, the mother terminates the feeding, brushes off the pups, and leaves the nest to take a break.

In our research, we sought to determine whether naturally occurring individual differences in any feature of this cycle might be relevant to brain development. For 8 hours a day we observed the maternal behavior of a number of mothers of intact litters without manipulating the environment. The animals were simply mated and allowed to rear their young. We found tremendous naturally occurring variation in the degree of licking and grooming.

We then conducted a median split, still observing naturally occurring variations within a normal range. We selected litters whose mothers showed high levels of licking and grooming compared to those who showed low levels of licking and grooming. Two things were noteworthy. First, the difference in licking and grooming that exists between these mothers is most prevalent during the first week of life. This is an active period of development of brain synapses in the rat. Second, there is no overall difference in the amount of maternal care associated with licking and grooming. The mothers who showed low levels of licking and grooming spent as much time in contact with their pups as the mothers who showed high levels of licking and grooming. By any measure, these mothers are perfectly competent. They rear their young to weaning, and their young are of the same weaning weights as those of high-licking and grooming mothers.

What is the impact of this difference in maternal care—the licking and grooming—for the offspring? The entire neuro-circuitry is developed in a very different manner in the offspring of high-licking and grooming mothers compared to those of low-licking and grooming mothers. In essence, the hardware is attached by altering the activity of the gene that produces corticotrophin-releasing factor (CRF)—the hormone that drives this entire response.

When one examines these animals as adults and exposes them to a single period of short-term stress, one finds that the offspring of the low-licking and grooming mothers show a greater hormonal response to stress than do the offspring of the high-licking and grooming mothers. A highly significant difference exists in the pituitary hormones and the stress hormones, the glucocorticoids. The difference is highly correlated with the level of licking and grooming that the pup received during the first 10 days of life.

One can start to account for naturally occurring individual differences in an animal's stress response by knowing the maternal care that it received. Again, by examining variations in maternal care within a normal range, we know that this alters the software of the system by increasing the production of CRF and the activity of the gene. A measure of the activity of the gene for CRF in the hypothalamus is about twice as active in the offspring of low-licking and grooming mothers. Because it produces more of this gene, this entire circuitry is more reactive to any form of stress that impinges upon it. In fact, we have differentiated not only the gene activity in the hypothalamus but the entire neural circuitry that guides this particular response.

One not only regulates the animal's endocrine response; one also regulates its emotional response to provocation. To measure this, animals are placed in a novel environment, and the degree to which they explore is observed. Animals who are scared or timid show substantially less exploration than do animals who are less afraid. The amount of exploration over a 5-minute period in the offspring of high-licking and grooming mothers is substantially higher than the amount of low-licking and grooming mothers.

Some of the questions that have been generated over the years in developmental psychology can now be explored closely. For example, one can ask whether these variations are transmitted from one generation to the next. From the work of Francis and others, one knows that the high-licking and grooming mothers are animals who themselves are less fearful. They show a reduced pituitary adrenal response to stress in contrast to mothers who are low lickers and groomers.

The next question is whether mothers who are less fearful and are high licking and grooming also had offspring who themselves become high-licking and grooming mothers. The answer is absolutely yes. If one mates the offspring of high-licking and grooming mothers and the offspring of low-licking and grooming mothers, one produces females that show the same difference as did their mothers. Thus, licking and grooming patterns are transmitted from one generation to the next.

One hypothesis regarding the mechanism of transmission is that information is genetically inherited and passed on. In order to test that question, we superimposed a particular manipulation on these animals. We took a population of animals, and we handled the pups for a short

period of time each day—about 5 to 10 minutes. When pups are handled each day, the amount of licking and grooming that the mother affords to that pup is increased. Regardless of whether the mother is a high or low licker and groomer, she will show higher levels of licking and grooming if one handles her offspring.

If the mechanism of transmission is genetic, one would take a group of females who have a genetic background of low licking and grooming and handle their pups. The handling course makes the mothers behave as if they are high-licking and grooming mothers. If one assumes that the genome is the primary factor, however, it would not make any difference how the mother behaves: The mothers will still be low-licking and grooming mothers, as will their offspring. On the other hand, if one assumes that there is a non-genomic mechanism of transmission and that the mother's actual behavior is primary in transmitting this information, then despite their genetic background, the mothers will behave as if they are high lickers and groomers and their daughters will become high lickers and groomers as well. It will depend on the behavior of the mother, not on her genetic background.

The offspring of high lickers and groomers are high lickers and groomers regardless. The critical comparison is the handled pups of low-licking and grooming mothers to the nonhandled. The genetic hypothesis would suggest that these animals should be the same regardless of how their mothers behaved. However, the evidence suggests the contrary. The data provide evidence for the behavioral transmission of traits from one generation to the next.

The next question is what is actually being transmitted? The evidence indicates that decreased fearfulness is the major component. Mothers who are low lickers and groomers are more fearful and transmit this to their offspring. The more fearful offspring themselves become low lickers and groomers. If anything alters this trajectory and produces a less fearful animal, it will become a high licking and grooming mother.

One assumes that the low-licking and grooming animals possess a pessimistic scenario of development. Mothers who are under high levels of stress—e.g., low levels of resources, high levels of predation, high levels of violence in the community—show compromised maternal care. This, in turn, alters the development of their offspring by producing an increased gene expression of CRF. These animals become behaviorally more fearful. Is this inevitable? This is clearly the scenario that is derived from early postnatal care, but it is not inevitable; it is entirely reversible.

Francis' research has shown, for example, that excessive fear and high levels of stress hormone responses found in animals that underwent maternal separation can be reversed completely with environmental enrichment. Animals who underwent a period of maternal separation in early life but in adolescence were exposed to environmental enrichment do not differ one bit from controls in terms of their stress reactivity.

This same pattern occurred in a somewhat different scenario as well. Low levels of licking and grooming alter not only the animal's emotional and endocrine responses to stress, they alter the pattern of the synaptic development in brain regions, such as the hippocampus, which underlie processes such as attention, learning, and memory as well. Lu has found that when looking at proteins that are normally associated with synaptic development, one sees greater evidence of proteins in animals that are the offspring of high lickers and groomers compared to low ones. This simply means that there is more of that synaptic protein in the offspring of high-licking and grooming mothers than in offspring of low-licking and grooming mothers. The same pattern occurs if one examines synaptofisen. The hippocampus in the high-licking and grooming animals is forming more synapses.

Those synapses are associated with the neurotransmitter acetylcholine. The medial septum produces brain cells that release acetocholine in the hippocampus. This is a critical neurotransmitter pathway for attentional processes, as well as learning and memory. Because they have more cholinergic synapses, in adulthood the offspring of high lickers and groomers release more

acetocholine under conditions of challenge than do the offspring of low lickers and groomers—a very substantial difference in acetocholine.

The differences in learning and memory in these animals in adulthood is predictable. When you expose these animals to a spatial maze, the adult offspring of high lickers and groomers learn far more rapidly than those of low lickers and groomers. Again, this difference is substantial. It suggests that naturally occurring variations in maternal care can actually regulate not only the pattern of synaptic plasticity in the brain but also substantial differences in the ability of these animals to learn and remember under certain conditions.

Taking the offspring of low lickers and groomers and exposing them to postweaning enrichment can bring a pattern of reversal similar to that as mentioned before. We have examined this by assigning the offspring of lowlickers and groomers and highlickers and groomers to either controlled laboratory conditions or to an enriched program. The low-licking and grooming offspring in the control clearly showed learning impairments. Low-licking and grooming pups raised in the same way but produced in an enriched environment completely reversed the pattern of cognitive deficits in these animals. However, the enrichment had almost no effect in the offspring of high lickers and groomers. A differential effect occurred only with what we might think of as the more compromised population.

I want to underscore that we are not talking about an aberrant, abnormal form of maternal care. We are talking about variations that occur within the normal range. The pups that develop with the high levels of stress reactivity, the attentional deficits, and the learning problems are not pups showing disease states, illness, or pathology. They have adapted to their particular environment and have adapted to specific signals emanating from the single most important event in their environment: maternal care. They respond to events by becoming more stress-reactive and by dedicating fewer of their resources to things such as the growing hippocampal synapsis. This is a highly adaptive pattern in an animal maturing under conditions where resources are limited.

If you are not going to get a lot of food, if you are going to grow up in a highly stressful environment, then you better have a very reactive set of pituitary adrenal and sympathetic responses. If you are growing up in a violent, dangerous, and deprived environment, then do not bother investing a lot in synaptic investment in the hippocampus. It is a luxury you can not afford.

Additionally, animals that grow up under a pessimistic state are highly distractable. The reason they are distractable is that they are hyper-vigilant. They are wary, extraordinarily cautious, and fearful. Hyper-vigilance is not a bad trait if you grow up in an environment filled with predation and violence. I would suggest that these are naturally occurring and adaptive patterns to specific forms of environment, and the reason is not because their mother is a castoff or a writeoff. It is because she herself is responding to an environmental set of signals which compromises her maternal care. In doing so, this compromises the pattern of neural development; it programs the activity of specific genes, and it results reliably in phenotypes of animals that are more fearful and less cognitively astute.

Charles Nelson: Suddenly, we have discovered that the first years of postnatal life are important, that there are critical periods for various aspects of development in the first few years, and that those years are a period of rapid change. The demands of language development, perceptual development, and emotional development all illustrate this. On the other hand, there is also work from the neurosciences that suggests that the brain has the potential to be modified during much of the life span, not just the first few years of life. Furthermore, in some instances, there are aspects of brain development such as the formation of synapses that extend over the first several decades.

The question is, how do we reconcile these two views: the neuroscience view that there is the potential for tremendous plasticity and changes in the brain for many years and that learning

and memory are the quintessential examples of neural plasticity because we do that throughout the entire life span, and the view from developmental psychology that sometimes paints a more dour picture than the neuroscientists.

The way to reconcile these two views is to look at those domains of behavior that depend only partially on experience but that perhaps have a strong genetic component to their development rather than those that depend exclusively on experience. The development of the visual system is a classic example.

I will cover two areas in my presentation. First, I want to talk about the various ways experience influences the brain and do so in the context that these can occur over many years. Second, I want to basically explain how it is that we can study brain function. I want to do this for two reasons. The first is that if we assume that experience influences the brain, then it is incumbent upon us to examine the brain directly in order to show how it has been changed. The second and related reason—for those of you interested in intervention—is that it is important to realize that there are now methods available that will permit you to examine how your interventions actually get into the brain.

I will provide a brief precis to human brain development to provide context for this discussion. Within the first 2 to 3 weeks after conception, the primitive neural tube forms. A layer of cells gradually begins to thicken and form a groove, which then forms the neural tube. This is concluded by the 25th day. An error in this process leads to a neural tube defect, such as spina bifida or anencephaly. Once this tube is formed, roughly from the 25th day or the end of the first month to about the end of the 5th or 6th month, premature neurons or neuroblasts begin to migrate in a radial direction until they eventually form six layers of the cortex. Each successive layer is formed by migrating neurons that go through the originally formed layer, and as a result, this forms in an inside-out pattern. The cortex has six layers by about the 5th or 6th month. At about that age, the brain is mostly smooth in appearance. The reason is that after the completion of cell migration, those neurons begin to set up shop, develop axons and dendrites, and begin to form connections.

The functional development of the brain is largely made possible by the process of synaptogenesis. The process of producing synapses is very complex and varies by domain, at least in the human. All regions of the brain—the visual cortex, the auditory cortex, and the prefrontal cortex—massively overproduce synapses. Then, there is a process of retraction where we begin to lose synapses. In the visual cortex, we typically overproduce synapses in the 1st year or so. Typically, by the time a child completes the preschool years, they have attained the same number of synapses as an adult.

The auditory cortex is a slightly more delayed function. Most relevant to this group is the prefrontal cortex. The prefrontal cortex, which is the expansive tissue behind the forehead, essentially subserves higher cognitive and emotional functions. Inhibition is one example of emotion. Examples of cognition include the use of strategies, planning behavior, working memory, and hypothetical deductive reasoning. These areas of the brain have different developmental trajectories; the prefrontal cortex is the last to show an adult-like pattern. The question is, what is the significance of that? People believe that it is this overproduction and then retraction of synapses that underlies the capturing of experience and then, essentially, the reorganization of the brain. Let me provide an example of adaptation. Humans have adapted to experience by making a more efficient and thus smaller brain.

Next, I would like to discuss plasticity in the immature organism. Prenatally stressed rats show increases in emotionality in response to novelty. If you rear these rats in complex environments or handle them at birth, they are in fact less reactive. Prenatally stressed monkeys exhibit symptoms of neural behavioral dysfunction. Schneider has shown that if you expose a pregnant monkey to unpredictable loud sounds, the offspring wind up showing symptoms of what I will refer to as neural behavioral dysfunction: they startle more easily; their catecholamine system is a little bit haywire. These behaviors are still present as the animals approach adulthood.

Collectively, early deleterious experiences can have long-term effects. On the other hand, Dr. Meaney has also shown that these early experiences can be mitigated with certain interventions: handling would be one and raising in complex environments would be another. There is ample evidence that early experience plays a critical role in the cultivation of the brain and in behavior. The same phenomenon is true in the mature organism. Black and Greenough have done elegant studies rearing rats they refer to as acrobatic rats, which have to learn very complex motor skills. Learn is the key word.

These animals show increased numbers of synapses per neuron within the cerebellum in comparison to inactive controls. In contrast, animals exhibiting greater amounts of motor activity on a running wheel, treadmill, or yoke controls, where they just run a straight alley, do not show any of changes in synaptic contacts. Moreover, only rats in the learning paradigm showed structural changes in the brain. That is the density of capillaries involved in the region, in this case, the cerebellum. There is actually a shift anatomically in the metabolic demand of the brain.

In other words, because of the greater activity in the cerebellum, the rats needed to sprout new capillaries that showed an increase in blood flow and increase in oxygen. These changes in synaptic contacts or in the metabolic arena did not occur when learning was not required. Learning itself, and not simply the repetitive use of synapses, leads to changes in the cerebellum, and that is an important point to stress.

A study published several years ago in *Science* looked at stroke intervention using adult squirrel monkeys. The investigators used a procedure called magnetic encephalography (MEG), where essentially anywhere there is an electrical current in the brain there is a corresponding magnetic field. Magnetic activity, unlike electrical activity, propagates in a fairly linear way through the brain and can be measured; it is of course very small.

Using magnetic encephalography, the researchers mapped out the motor cortex, the part of the brain that represents how the body is controlled. They were able to identify precisely where the forearm was represented in the brain. They trained the animals to retrieve a food pellet. Then, they induced a stroke—an ischemic injury, which basically means lack of blood in that part of the brain—rendering the animal without use of the arm, much as would occur in a human condition. Then, they trained the animals in intensive intervention so that eventually they regained the use of their arm to preinjury levels. They used MEG again to look at the motor cortex and found there to be a dramatic reorganization in the motor cortex that represented that limb. The point is that the reorganization of the motor cortex was based on a very specific intervention, and this could be observed using magnetic encephalography.

This raises the question of whether or not this phenomenon of reorganization in the cortex is restricted to cases of injury. Are there examples of a reorganization following some noninjurious situation in healthy individuals? Elbert and his colleagues have published a paper looking at the somatosensory cortex in both trained musicians and people who do not play a musical instrument. Somatosensory cortex is the area of the brain that receives the input and represents the body in many respects.

They examined people who played stringed instruments, such as the guitar and violin, and using magnetic encephalography, they mapped out the somatosensory cortex. They realized that the part of the brain in the right hemisphere that represented the fingers of the left hand—which are used on the fingerboard—was much larger than the area in the right hemisphere that only represented the bowing movement. Of course, it was much larger in the right hemisphere of musicians than in nonmusicians. It was also much larger than the thumb area, suggesting that this highly practiced movement that involved learning resulted in a reorganization of the contralateral hemisphere only in musicians.

Also, it has been suggested that the effect was larger in those individuals who learned the instrument before the age of 10. Is it a question of an effective early experience versus extensive training? Scientists have controlled for that by taking adults with absolutely no musical experi-

ence and giving them extensive experience. The effects are still not as big as when it is learned before the age of 10. This is an example of cortical reorganization following skilled motor learning.

My last example is work by Tallel and Merzenich. They demonstrated that children with language-learning impairments, who have this impairment due to an inability to parse the speech train coming at them too fast, would show a dramatic increase in their speech discrimination abilities and in their general language abilities with intensive training. It is a relatively brief intervention done during school age that appears to show a dramatic change in behavior, and they have not yet looked at brain level. But presumably, there was reorganization in the auditory thalamocele-cortical pathway, which is what is behind this ability to parse the speech train.

Collectively, there is the possibility of reorganizing the cortical pathway in the adult human beyond childhood, and this reorganization is not limited to motor or sensory pathways and may include cognitive or language systems as well.

This does not deny the fact that in some domains critical periods are a real phenomenon, and it does not deny the fact that early experience is important in the development of certain behaviors. Finally, it does not deny the fact that it is important to intervene early to exact solid behavioral change.

My purpose in reviewing these findings is to question the simplistic notion that beyond the first few years of life, the brain is unbendable and increasingly difficult to modify. The fact is many aspects of brain function can be modified well beyond the first years of life. The more important question is not whether there are critical periods, which we know there are, but rather in which domains are there critical periods? We know there are critical periods in the vision and sensory systems, and probably in language, although it varies by domain. We know less about cognitive systems, which, I would argue, probably have much less of a critical period than the sensory systems.

What are the neural processes that regulate these critical periods? Is it only synapses or are there other changes going on at the same time? What environmental conditions occur that result in a sparing of function or recovery of function? Sparing, of course, occurs when despite some deleterious early experience some children do not succumb to that injury or deficit. Conversely, those who do succumb and exhibit a deficit can often show recovery of function.

The question is, what neural mechanisms mediate this? Finally, how can we assess the changes that occur in the brain, due to the presence or absence of some experience? This provides a segue to the second part of my presentation: How do we study the brain in the developing infant and child? The challenge is considerable. For example, in the context of the infant, we have an organism that cannot walk, talk, or push buttons, and has an attention span on the order of nanoseconds. Thus, most of the behavioral and neuro-imaging tools used with children and adults are not available.

One tool we have great success using is the historic way of looking at the localization of function. That is, what parts of the brain subserve which functions? This is phrenology that goes back more than 100 years. We have a class of electro-physiological procedures, whereby we primarily use event-related potentials that represent the synchronous activity of large populations of neurons in the brain responding to some discrete event. In other words, by placing electrodes on the surface of the scalp, we are able to record brain activity that is elicited by some task. The traditional method consisted of placing up to 18 electrodes on the infant's head held on with headbands.

More recently, we have used a more advanced procedure where we can place anywhere from 64 to 128 electrodes on the infant's head, which allows us to record from many brain areas closely spaced apart.

Let me give you one example of a project we have done. If a 9-month infant is shown a sequence of events and then brought back weeks later, many infants will spontaneously repro-

duce the sequence showing evidence of almost recall memory. At the age of 9 months about half the infants will do this. An example of the sequence follows: A cylinder is put in a block, the block is slid into an opening, and then a little object pops out. We brought in 9-month-old infants, showed them the sequence, but did not let them practice it. One week later, we brought them into the lab and recorded their brain activity as we showed them pictures of those objects that they had seen previously and pictures of novel objects. We did not show them in sequence, but randomly. The question is, would their brain activity discriminate objects they had seen in the sequence from objects they had not?

A month later we brought them back to the lab, gave them the props, and watched whether or not they would spontaneously reproduce the sequence. We observed that half the infants did and half the infants did not. Upon examination, among the infants who demonstrated recall, we found a clear pattern of difference in brain activity between the response of the novel objects and the familiar objects. However, the infants who showed no evidence of recall showed no differences in their brain activity. This provides evidence of being able to predict which infants will show evidence of recall based on the pattern of electrical activity recorded from their brain.

More recently, we have begun to use a class of behavioral tools, neuro-psychological tools, with older children, typically preschoolers and above. This cannot be used with infants. They are typically adopted from studies of animals with discrete lesions to better understand the correlation between brain and behavior. We want to use these tools to look at the correlation between brain and behavioral development. We ask children to plan a sequence in order to examine their ability to plan the behavior. They are scored on the number of moves, and each task increases with difficulty.

This becomes very difficult with moves that have four or five sequences. We find a pattern of dramatic improvement across time in the ability to do this sequence, suggesting that this follows the pattern of synaptogenesis that I reported earlier. We do not find children behaving like adults in this task until they reach early to midadolescence. This means their use of planning and strategy and their working memory capacity is tracking this process of the retraction of synapses in the prefrontal cortex.

Finally, let me turn to another procedure we have used with children—functional magnetic resonance imaging. Essentially, this is a technique based on the principle of measuring changes in oxygenation in the brain using magnetic resonance technology. We present a subject with the task, and as is the case with PET, whatever part of the brain is most involved in performing that task will show the largest increase in oxygen. We measure the shift in oxygenation using MRI. It is completely noninvasive, unlike PET where you need to inject a radioactive tracer to watch for the decay in radioactive oxygen.

To conclude, the brain is remarkably plastic for many years. This is not to deny the importance of critical periods and early experience in some domains. Nevertheless, there is a great deal of malleability in other domains. Any lasting changes in behavior must be accompanied by changes that occur at the level of the brain. There are methods that currently exist that permit one to examine brain function in the developing child. Lastly and perhaps most relevant, these same methods can also be used to evaluate the success of a given intervention, as was the case in the stroke intervention presented earlier. One can easily see that in the context of Head Start as well. From my perspective, I would like to see how current interventions, including Head Start, actually get into the brain, and what is going on at the level of the brain that makes possible the changes we see in behavior.

Dana Johnson: When I began my foray into the field of adoption medicine back in the early 1980s, the vast majority of children who were coming to the U.S. from abroad came from Korea. Over the course of the next decade this dramatically changed, beginning in 1990 and 1991, when we saw a massive immigration of children out of the orphanages in Romania. Now, two thirds of children come from Russia and China. However, it is not just the countries of origin

that have changed. More importantly, the caregiving environment in which these children found themselves prior to placement in the U.S. have changed dramatically as well.

In 1986, two thirds of adopted children came from Korea, where foster care was the norm for children adopted into this country. However, in 1997, which is the last year we have statistics from the federal government, only 12% of adopted children are coming out of foster care situations and 88% are coming out of congregate care settings, such as orphanages or hospitals.

Institutionalized children are obviously a very high-risk population, and this poses a great deal of difficulty in studying normal brain development. Women who place children within the orphanage systems in the countries where these children are coming from often have very poor prenatal care and many of these children are either premature or have extremely low birth weights. They also are exposed to a variety of toxins, including alcohol and lead—alcohol particularly in Eastern Europe and lead in China. Worldwide, these children have nutritional deficiencies, such as iron and vitamin D, while iodine deficiency is a particular problem in China and Central Asia. They have been exposed to physical and sexual abuse within institutions; there is a great deal of heterogeneity in terms of institutional care environment—some good, but mostly bad. They also have a wide variety of medical problems, including intestinal parasites, hepatitis B, syphilis, and other transmittable problems.

In other words, they are difficult to look at as a normal population exposed to extreme deprivation. However, they are identical to the population of children who are coming from at-risk homes in our country and who live in the foster care system within our country, your clients in the Head Start system. These children are different because they are coming out of circumstances of extreme deprivation, and they are going into what many would call optimal environments. These families have all been screened; they have all had a home study; they have all been designated by social workers as being fit parents; they are financially stable; they have enough money to go into international adoption, which costs upwards of $20,000 per child; and they are doting parents.

Orphanages are like many diseases that we see in medicine, such as tuberculosis, which we were so successful in treating that it almost disappeared and when it came back, many of us had to go back to the textbooks. It is the same for orphanages. We had orphanages in this country until the late 1950s and 1960s when they were replaced by the foster care system. Most orphanages are not good. However, there are some good orphanages in the sense that they try to do the best they can with the limited resources at their disposal. They have one-to-one relationships with their children, provide good educational experiences and a variety of sensory experiences for the children, and attend to their individual needs. These children have a chance to experience love and affection from single caregivers.

However, there are not many situations like this within congregate care settings. Most children are in situations that literally could be described as concentration camps for children. Life is very dull. They spend most of their time within individual cribs with very little interaction. What interaction they do get is usually from peers who have the same problems that they have and are not stimulating one another at all. There are no adults around to teach them the daily tasks of life, and very few are available to show them even how to play. Life within the orphanage is very rigorous; it is very stereotyped. Children do the same thing every day of their life. The approach of most orphanage workers toward the care of the children is a medical model, not a maternal model. Usually, the ratio of caregivers to children within an orphanage setting is 8:1.

If we have a child with trisome 21, trisome 18, or a deletion in some of their genetic material, they will have abnormal brain development. My revelation was coming face to face with the fact that for early development, for normal brain development to occur, there needs to be adequate environmental interaction. Environmental in the sense of caregiver and peer interactions to promote normal brain development. It is no more rational to expect a child with environmental deletions from an orphanage situation to have normal brain development any more than we

would expect a child with genetic deletions to have normal brain development.

Indeed, the classic studies published by Provence and Lipton in *Infants in Institutions*, based on studies done in Connecticut in the late 1950s and 1960s, show a sequential decrease in IQ as children live in the orphanage for a longer period of time through their first year of life. More contemporary studies in Russia looking at children from working class families who lived with their family but spent 12 hours a day within day care, compared to children 6 to 7 years old who lived within an orphanage, found a 20-point decrease in IQ. We also see that the orphanage not only has an effect on what we can measure in terms of intellect but also on head circumference, an easy way of looking at brain growth.

One study examined brain growth of 236 children who were placed within the orphanages throughout Russia. Normal brain growth in orphanage children starts slightly lower than the mean and then deteriorates in terms of their growth through the first 12 months of life. They stabilize through the next 2 or 3 years and then maybe have some recovery later on. Even looking at this gross measure of brain development, we can see that an orphanage environment with its lack of stimulation leads to very poor brain growth.

Additionally, because it is not a stimulating environment—and much of our development depends upon sensory stimuli to develop normal neurologic function—there is a very high incidence of strabismus within the orphanage, which leads to further difficulties in trying to determine how these children relate in terms of visual/spatial activities. The same thing occurs with auditory processing deficits as well.

What are the long-term effects? There have been a number of studies recently on Romanian children. None of them has been done in the U.S., two have been done in Canada, and one has been done in the United Kingdom. Ames conducted the most comprehensive study looking at children who arrived after spending 8 months or more in the orphanage. We saw the same deterioration in cognitive skills. Children who arrived after 2 years of age had the lowest scores in terms of their cognitive ability. We also saw abnormalities in attachment. The important thing was what happened after these children had been within a nurturing environment in their adoptive family.

Even after they were in a nurturing environment, we still saw the effects of being in the orphanage. If they had spent less than 4 months in an orphanage, there was no difference between the control groups. However, children who had spent 8 months or more in an orphanage, even after they had been within a nurturing environment for 3 years or more, had fewer secure attachment relationships and more were indiscriminately friendly. We saw persistent behavior problems at 4½ years of age approximately 3 years after arrival. These had gone from internalizing behaviors, when they first arrived, to externalizing behaviors; the children were aggressive, antisocial, and undercontrolled.

Data were collected related to social behavior 3 years after arrival. Fifty percent of the children were rated out of the ordinary using measures administered to parents and teachers. Other children did not like these children; they were more hostile, aggressive, distractible, and poorly-controlled; they were hyperactive and had poor attention spans.

One can look at this as the glass being half full or half empty. Even after the most obnoxious rearing conditions that a child could endure, where there was no stimulation and no love, one third of them had made wonderful progress. These children were basically normal in the eyes of their parents and their teachers. Another one third had a few serious problems but were making substantial progress. However, 30% continued to have significant difficulties.

The children discussed above were basically adopted by the time they were 3 or 4 years old on average. What happens to children who endure profound and prolonged deprivation? In Romania's system, after 3 years of age children are tested. If they appear to be neurologically intact, they go on to regular orphanages. The children who have problems are placed in what are called institutions for the irrecuperable or the neuro-psychiatric institutes. A "20/20" episode was done in the early 1990s showing an irrecuperable orphanage where they used to have 2,500

children housed under deplorable conditions. It is now down to 540. I had the opportunity to visit it 2 weeks ago. Once children are placed here, the only remaining step is to enter adult psychiatric institutions. Most of these children spend all day in their cribs, or sitting around tables without meaningful activity. Some are totally divorced from reality. I learned from visiting this orphanage that it is very difficult to stifle the human spirit. Amidst these children, who clearly are profoundly affected, there are children who still smile and are intact.

What have institutionalized children taught us? Clearly the brain is very plastic. One can endure an enormous period of deprivation during critical periods of development and still recover when placed in a nurturing environment. However, we also know that although the window of opportunity may be closing, it is never closed completely. Nonetheless, it takes much longer to catch up in certain areas, such as speech and language development, than it does for motor development. Finally, even under the most inopportune situations, there are still children who are resilient and who do extremely well.

Robin Karr-Morse: Until a few months ago, most people thought of Oregon, my home state, as a sleepy little mecca of progressively environmentally conscious folks, a place where a lot of people think about going to get away from everything. Jonesboro, Arkansas seemed a very far away. Then Jonesboro came to Oregon, landing in Springfield, a community about 100 miles from Portland, following the school shooting by a student. The media and even the President converged on Oregon to create major forums on the causes of violence and what could be done to prevent it.

Topping the list of causes were once again the availability of guns, copycat crime, the lack of after-school programs, and television violence. However, even taken together, guns, TV violence, lack of programs, and copycat crime do not explain why or how. How can two rural boys plan and then systematically stage a horrific fire drill to gun down other children? What is going on when a 6-year-old leads 8-year-old twins to a month-old baby sleeping in a bassinet in California and then proceeds to beat and kick the baby almost to death? How in the course of a dozen or even a half a dozen years can a baby metamorphosize into a vicious killer? These children do not emerge out of a developmental void. Rarely do they strike without a history of serious warning signs. However, our response to crime in this country has been to wait, to offer late-stage programs for out-of-control adolescents, to get tough on crime, to increase and restructure policing, and, of course, to build more prisons.

Currently, the U.S. has the second highest rate of incarceration in the world, second only to Russia. One in three homes built in this country today is being built behind bars. As of 1995, more than 5 million Americans are living under the control of the criminal justice system, compared with 6 million Americans enrolled in colleges and universities across the nation. If this trend continues, we will soon have more people in prison than in higher education. California already spends more on its criminal justice system than on higher education.

According to the most recent data released by the FBI, at our present rate of incarceration, 1 in 20 children born today will spend some part of their adult lives in jail or prison. Children are now the fastest-growing segment of the criminal population in this country. Last year nearly 1 million children under age 15 were arrested for felonies. As the age of violent offenders drops and the brutality of their crimes increase, judges, police, and social service workers across the country are struggling with how to cope with children who are too young to shave, and in some cases, too young to tie their own shoes.

No one in this room disputes our right as a society to protect ourselves. However, the bankruptcy of our traditional approach to crime reduction and our total reliance on a crisis orientation becomes apparent as the faces of these children grow younger and the lines between perpetrators and victim become increasingly blurred.

Exactly how do we effectively remediate—let alone get tough on crime—when a child sets fire to his apartment building killing 8 people and sending 15 others with critical burns to the

hospital? My understanding is that this child has a permanent cleft in his cranium where his father hit him with a clipboard as a toddler. This was the same father who weaned his son at 18 months of age by putting his baby bottle in a pan of rubbing alcohol and setting it on fire in front of him.

Will this child become a child who is remorseful or who even comprehends what he has done? Probably not. Will he become capable of complex thinking that would allow him insight into his own or other people's intentions? Probably not. Will he develop the ability to formulate constructive alternatives to impulsive behavior? Maybe. Generalizing those to future situations, however, may be challenging given this boy's history of emotional and learning disabilities.

What is the future for the little 6-year-old who led the 8-year-old twins to the baby? That little boy is the child of a drug-addicted mother who frequently saw her brutalized by boyfriends and whose own father was murdered on the street when he was a toddler. Viciously disciplined and attached to no one, this child was so full of rage by age 6 that his own uncle said that he was surprised that this little boy avoided killing someone for as long as he did.

My writing partner, Meredith Wiley, and I spent the last 4 years researching this topic. We have interviewed several of you in this room and others, and what we have found is that the roots of violence often begin in the womb and can be well-entrenched by preschool. We can talk about plasticity and certainly this is a factor, but the reality is that our spending patterns in this country do now allow for the kind of resources that are important to turn this trend around.

If our goal is to understand the violent behavior in which the U.S. is now submerged, we have to, with rare exceptions, look before adolescence, grade school, or preschool to the cradle of human formation in the first 33 months of life—the 9 months of gestation and the first 24 months after birth. This is not to say that later events do not count, but rather that what happens early biologically and psychologically creates either relative receptivity to or relative resistance to factors that may catalyze violence later in the child's life.

Factors such as the availability of guns or violent modeling on television are absorbed very differently by a brain that is rageful and detached than by one that is connected and empathic to other people. Perry probably says this best: it is not the finger that pulls the trigger; it is the brain; and the brain begins in the womb. The fact is that violence, like all behaviors, is brain-based. The routing of violent responses or of capacities that mitigates against violent behavior begins when the brain starts forming in the womb.

We have listened to a great deal of research this morning. The fact is we are synthesizing a great many streams of research that speak to this problem and the roots of violence never stem from a single source. Nature and nurture each play a part. Biological factors like prematurity, or the effects of drugs in-utero, or birth trauma, or tiny brain hemorrhages, or ADD, or difficult temperaments can render an infant vulnerable. When these biological conditions affecting infants are compounded by social factors affecting their families, factors like mental illness, domestic violence, drug abuse, immaturity, or criminal involvement, the results can be the toxic recipe for abuse or neglect of the child's developing brain at critical points in early development. What the new brain research provides is simply the graphic, physiological evidence of how this can set the stage for later violence.

I want to discuss one concept in brain research and take a simplified look at how each episode of abuse and neglect can affect the brain in terms of this very basic concept. To me, the most remarkable discovery of all about the human brain is simply that unlike any other organ in the body, for example a heart or a kidney or a liver, the brain is actually designed to complete itself; to complete its development in response to the specific stimulation it receives in a specific environment.

This is electrifying information for those of us who thought the brain simply developed on a course preset by genetics like every other part of our body. Sensual input—sound, sight, touch, movement, and taste—all build gray matter in the developing brain. Experience shapes brain tissue, brain chemistry, and organization. We have seen evidence of that this morning and never

so formatively as in the earliest stages of life. However, when adequate stimulation is not forthcoming, as in cases of chronic neglect or when these experiences are abnormal, as when a child is abused or exposed to chronic trauma, the brain reflects these realities.

Not only does the brain rely on the environment to build basic circuitry, but researchers have also found that when it comes to brain cells, like muscles elsewhere in our body, we either use them or we lose them. We know that brain cells communicate by hooking up with each other by forming synapses. These connections between the neurons—their quality, their quantity, and their stability—are what determine our adult potentials. Those synapses that survive and those that do not are determined almost entirely by use. Repeated use stimulates the strength of a synapse, and if the use is strong enough, the synapse remains stable and protected, often into adulthood. Synapses that are used can become permanent, but those that are not tend to be eliminated or pruned.

Probably the most graphic example of this was demonstrated on "20/20" last year. The program focused on children in a Romanian orphanage. In one example, a nondeprived girl and a Romanian girl, both 7 years old, were asked to repeat a number sequence. The brain of the nondeprived child then was shown in a PET-scan and reflected bright colors on the screen when the child was asked to complete this task. But when the Romanian child was asked to repeat the same sequence, the vibrant colors were missing from her PET-scan. The area of her brain that should have responded to the task showed no activity.

Given several tries, the little girl looked into the camera and could not do it. "It's a black hole," said the voice over the program as the viewers were shown the colorless shadow in this area of her brain. Adopted before age 2, this little girl could speak, but she could not remember simple information like a three-number sequence. The brain cells once available to process this task were never stimulated and are now lost to her permanently.

When children can stick a knife in a puppy and eat an ice cream cone at the same time, or kick and beat a sleeping infant, they are reflecting what they have absorbed or not absorbed. When the child's brain was available for connecting deeply, trustingly, and positively with a key adult, it simply did not happen. This function never developed or developed poorly, and having never been built within the parental or caretaking relationship, it can be lost to the larger world.

None of us would be surprised if we found that a child never exposed to violin lessons came to adolescence unable to play the violin. We seem surprised when children emerge who are totally lacking in empathy or positive regard for other people. However, growing numbers of children in this country are experiencing their first months in environments that are emotionally neglectful. In the U.S., 8,500 children a day are reported for child abuse or neglect. One out of 3 is a baby under the age of 1.

Reporters constantly use words like "senseless" to describe young murderers. This disconnectedness is not senseless. The causes are not unknowable most of the time. The fact is that these children, like all of our children, reflect what they have experienced. The brain is the physical reflection of that experience. There is, by the way, a tendency for people to think of emotional neglect in the same category as physical neglect, as a byproduct of either poverty or abusive circumstances. However, the fact is that emotional neglect is much more widely spread. Emotional neglect typically results from nonintentional behavior. It can be the result of parental depression or mental illness, immaturity, or even too many changes of early caretakers.

I saw a little boy 5 weeks ago in my private practice who came in with both of his parents who traveled regularly. This little boy had just been kicked out of his third preschool, and in the course of time that he was with me in my office for that initial hour, he kicked his mother, pulled her hair, and took apart my office. This child was so angry that he was uncontainable. In our country, ignorance and confusion about child nurturing, particularly emotional nurturing, and our ambivalence and lack of adequate support for high-quality care for infants and toddlers puts growing numbers of children at risk for emotional neglect across class and ethnic lines. This

little boy had had 14 different nannies in the course of his 4 years. At least initially, they had quit for reasons unrelated to the child's needs or personality.

Essentially, any experience that reduces the developing brain's ability to process rational information or to focus on learning, such as exposure to alcohol in the womb or any experience increasing the production of fight or flight brain chemistry—child abuse, exposure to domestic violence—can help set the stage for violent behavior.

The lower brain functions when a baby is abused repeatedly or is exposed to regular bouts of violence by people he looks to for care. The fight or flight mechanisms we all have to ensure survival will be highly stimulated because of the way the brain builds itself as use-dependent. This stimulation over time builds an overactive or hypervigilant response system. The fight or flight chemistry with these children can become permanently set on high. These babies become always on red alert for signs of impending threat in the environment.

Fight or flight systems constantly overstimulated will pull attention away from other crucial forms of learning. These children's brains are not fully available to focus on learning; they will not sit still in school because they cannot. They are busy monitoring the environment for signs of danger rather than sitting calmly focused on the lesson. They will often perceive relatively benign behaviors in others as hostile and are ready to respond, or they are the children who seem not to listen, who do not do what is asked because they simply are not there behind their eyes.

These children may look hyperactive and be labeled as learning disabled. They show increased muscle tone, temperatures, pulse rates, and startle responses, and often profound sleep disturbances. When they are boys they tend to become aggressive, impulsive, and reactive. They are often violent with little external provocation. When they are girls they tend to become disassociative, abstracted, and seemingly not there. They have tuned-out and turned within themselves. Originally adaptive to a threatening environment, these brain-based defenses become a huge handicap in the nonthreatening environment. School performance, IQ, and social relationships typically are all affected. Ten years ago teachers typically reported one or two of these children in a classroom. Now there are typically four or five. Experience shapes brain tissue, brain chemistry, and organization. When the environment is abnormal emotionally or is deprived of adequate stimulation, the baby brain will adapt accordingly.

Another way of understanding the reality of the roots of violence and where it is coming from is to simply take a moment and ask yourself what keeps you from killing. Often when I ask people this question, they will say well, "I know the difference between right and wrong; I know the 10 commandments." Everyone in this room has felt fear, rage and jealousy. Most of us have felt like we would like to clobber somebody at one time or another, but most of us have not killed. Why not?

For most of us the answers to this question comes within the category of three specific capabilities. The first is empathy. You may be furious from time to time with someone, but it would cause you psychological pain to hurt them. That feeling of internal discomfort when someone else is suffering begins with a connection between you and someone else a long time ago. It began when someone was there to respond to your cries and needs, looked you in the eyes, talked to you and gave you a sense of connection to that person in a positive way.

Empathy is a cortical capacity believed to be built in the orbit of frontal cortex, an area that is particularly responsive to facial expressions and tones of voice and that connects incoming sensual data—sound, sight, and touch and so forth—with internal body states. The responsiveness of the caregiver; the sensitivity to the baby's intended message; the warmth and timing of the adult's response; the availability of eye contact, soothing sounds and gestures all form the basis for feelings of pleasure and connectedness by the baby to the caretaker. These experiences of trust are the foundation for empathy and begin optimally inside of first relationships.

A second reason you may have never killed someone has to do with the fact that you know self-control of strong negative emotions. You may get upset, but know how to bring yourself

down. This ability was first provided by someone else when you were frightened by a loud sound or an unfamiliar happening. Over the course of time when babies are routinely handled sensitively, this ability called self-regulation, originally facilitated by the caretaker, is internalized by the baby, then the child.

The third protective ability which has its roots in gestation, baby and toddlerhood very briefly is the ability to problem solve; the ability to come to the 10 commandments and to apply them, to generalize them, to analyze why it is that someone might behave the way they are, and to talk yourself down from that very upset place. For a fetal alcohol child or for a child whose biochemistry is stuck on fight or flight, these can be very hard capacities to come by. All three of these protective capacities are optimally sown inside of a relationship between an infant and a caregiver in the first months of life.

In closing, I simply want to remind you that while preventing violence is an important goal we can achieve by investing in our children from the beginning, it is not the only thing we will accomplish by so doing. Violence is only the most visible and the hardest to ignore symptom of something much deeper that is amiss in our communities, a loss in civility, connecting and relating.

In 1962, Carson published her classic book *Silent Spring* that brought before us the possibility of a spring without songbirds. Carson revealed an unseen and insidious threat to the entire chain of life from pesticides then being routinely introduced at the front end of the food chain. A spring without songbirds was a chilling image, and in contemplating that thought we finally began to understand the intricate linkages that exist between the front end and outcomes when poisons are introduced at the front end of the ecosystem.

Now, more than 35 years later, we have yet to understand that a parallel dynamic is at work in the human system. Toxic experiences—family violence, abuse, and chronic neglect—along with toxic substances are being absorbed by our babies in record numbers. If Carson's image of a spring without songbirds produced enough concern in the 1960s to generate widespread efforts to reduce the poisoning of the natural environment, then perhaps there is hope in the 1990s and beyond for preventing the poisoning of the cradle of the human community. It is the sweetness and the vulnerability, the curiosity and the playfulness, the hopefulness and the innocence, and the trust and the arms outstretched purely to embrace or to help that are at stake in our times. We are facing not only the possibility of a spring without songbirds, but a future without people who care or notice the difference.

Jack Shonkoff: I would like to start my remarks with a question, "What do Head Start, Sigmund Freud, and pup-licking rats have in common?" The answer is they all affirm the concept that development is influenced by early experience. The next question would be, "How does it happen that experience influences development?" The answer is the brain. The tremendous increase in interest in brain science among those in the early childhood field is a combination of someone validating what our field has been doing but also recognizing that this is not a new science.

I would like to address two additional questions: First, how can we learn more about this process of development? Second, how can we use the increased knowledge that we are being introduced to, both from the neurobiologists and from those who continue to work in child development, to apply what we know to make the world a better place for children?

The first thing that came to my mind was that this is not rocket science. I do not mean that in the usual way, which is to say it is pretty straightforward. I think this is not rocket science because it is not as simple and elegant as rocket science. It is not the kind of science that will ultimately lead to a set of equations that will allow us to land on a specific spot on the moon. In many ways that is easier to figure out than how experience influences brain development which influences behavior. It is not as mathematical.

I suggest three answers to the question of how to think about using this new knowledge in a

way to make a difference. First, we need more research. However, more importantly, we need more support for the people who are conducting the kinds of basic neurobiological research that we have heard about this morning. We need more basic research in the processes of early human development, in all of the areas that people in this room have spent their lives thinking about, whether it is cognition or language or social or emotional development. We need more of this research to be interactive, and that is a big challenge. The MacArthur Foundation is supporting a new network that is beginning to address this issue.

Second, we need to be very wary of premature or inappropriate applications of new knowledge, particularly when it comes with the trappings of high technology, which are so seductive in this society. I have tremendous regard for the work people are doing on a functional MRI. It would be a tragedy, however, if we recreated the old right-brain, left-brain classrooms of the special education field. The exciting work taking place in neurobiology is a far cry from application for service delivery, and we need to be careful about that.

Third, we have to be incredibly sensitive to the political and the social context in which all of this is occurring. Two constituencies specifically come to mind. The first is the parent constituency that wants to know what experts think about how to raise children. We need to be very careful about that, particularly now that it has the imprimatur of biology and not just social science that people can easily push aside. The second constituency is the political constituency that decides how to allocate what have always been finite public resources. There is a danger of misuse of this knowledge to inappropriately target resources, or, in some cases, to have a good rationale for not using resources at all.

Next, I would like to address what the shared agenda is for neurobiology and the Head Start community. By a shared agenda, I mean what has to be done together. There has to be communication, interaction, dialogue, discussion, and a shared struggle between those who study the brain and those who work in communities with children and families. They need to begin to address a number of the concepts that were very elegantly presented by the members of the panel this morning at a higher level.

I will mention a few examples that came to mind. First, we have to better understand both the critical importance and the limitations of the proximal caregiving environment for early development. As I was listening to Michael Meaney's wonderful presentation on the rat pups, I kept thinking that about the fact the caregiving relationship exists in a laboratory. Bronfenbrenner and others have told us that when we put people in a laboratory, which for humans is an unnatural environment, we can only look at so much and miss much more.

I kept thinking about the sociopolitical and economic context in which a rat matures. What are the cultural differences among rats that influence the way rat pups think about themselves and decide about how they are going to treat their own offspring? I assume that there are not numerous large contextual issues for rats. My guess is that the broader cultural and political contextual influences on rat development are not as significant as they are for humans. If nothing else, there are important differences in the human brain from a rat brain that can be affected by some of the other things that go on in the larger environment. This makes it very important to distinguish between studying the caregiving environment of an animal from a human and generalizing or translating that data. What we have come to accept in studying human development is that laboratory walls distort the picture so much that we often miss what the major points are.

A second issue that both the Head Start community and neurobiologists who are interested in the implications of their work for human development need to struggle with together is what we mean by words that are spelled the same and pronounced the same but may mean very different things in different contexts, such as deprivation and neglect.

Deprivation and neglect for a caged rat without stimulation—no mazes, no interesting things to jump around in—is different from the concept of deprivation and neglect in a Romanian orphanage, which is different from the experience of deprivation and neglect for a young child

living alone with a depressed single mother, which is different from the concept of deprivation or neglect for a child in a poor-quality child care center.

It is the same word—deprivation, neglect, or whatever term we use—but we have to be careful about how we carry over what we may learn in one setting to another and think it is all the same. I particularly worry that the early literature in our field has sensitized us to the concept of deprivation. It is a big leap to talk about deprivation in a poor, low-resource family environment in a city or in a rural area and think that we are talking about the same thing.

I offer the same caution when we talk about stimulation. There is a difference between the stimulation of a cage for a rat that has many interesting mazes and running tracks and the stimulation that a child experiences in a contingent, well-resourced home environment and the stimulation that children are exposed to in a very busy, noisy, chaotic environment. These words are much more complex than they appear to be. We have to be particularly careful when we try to generalize or overgeneralize or translate from one research context to another.

I would like to read one last cartoon to you. It is two gentlemen at a bar with a caption that reads, "Then we've agreed that all the evidence is not in and that even if all the evidence were in, it still wouldn't be definitive." This is an important message with which I would like to end this morning's session. All the evidence is not in. There is a lot of evidence coming in, and there is a lot more evidence to come. I do not know whether there ever will be a day when all the evidence will be in.

My guess is that there will not, and my hope is that there will not. My guess is based on the assumption that we will never really be able to answer everything about how development happens and why it happens, particularly if we want to look at the full spectrum of human development and get beyond issues like an ability to stack blocks, including what it is that makes some people not have the inhibitions to do serious harm to others. Because I do appreciate history, I take it as a given that some day there will be an ability to answer all that. However, from my perspective, I hope we never get to that day. For me it would be similar to figuring out how to split the atom. There may be good applications for some things, but the consequences of what could be done with that knowledge are staggering. I do not know that any of us would ever want to live in that time when we understand everything there is about the developmental process, particularly when dealing with issues about being able to predict.

For me, as someone who is very invested in understanding more about how development happens and understanding more about how to influence it in a positive way, I would love to see us preserve some degree of mystery about the process of development, which in the end we know has something to do with the brain. Certainly, I would not want to think about what it would be like to raise children in a world where we knew everything and there was no mystery left.

Young Children with Challenging Behaviors: Prevalence, Screening, and Intervention

CHAIR: Edward G. Feil
DISCUSSANT: Steven R. Forness
PRESENTERS: Brenda Jones Harden, Monique C. Better, Edward G. Feil

This symposium presents research on reducing problem behaviors in preschool and primary elementary settings with methods ranging from staff training and screening to direct remediation efforts with young children at risk for the development of antisocial behavior. Studies have indicated that many behavior problems have their origins in early childhood. For some children, antisocial behaviors follow a progression of: (a) disobedience in the home, (b) temper tantrums, and (c) teacher reports of noncompliance, fighting, and stealing. Each step in this process puts the child at ever-increasing levels of risk for long-term social maladjustment. Without intervention, children with behavior problems and low academic skills risk increasing degrees of long-term social maladjustment, and remediation becomes more difficult with increasing age.

The first paper in this symposium describes a parent and staff development training package of interventions for impacting variables in the preschool years that are predictors for later substance abuse. The second paper describes a proactive, classroom-wide screening process for behavior problems for possible use in Head Start agencies. The third paper describes a classroom intervention to forestall the development of antisocial behaviors. This symposium provides participants with state-of-the-art practices in early intervention for children who are at risk for later development of delinquency and drug abuse.

■ Understanding the Mental Health Needs of Head Start Children: Prevalence and Correlates of Externalizing Behavior Problems

Brenda Jones Harden, Monique C. Better

Children raised in poverty are experiencing unprecedented challenges to their mental health, including exposure to family and community violence, familial drug involvement, and dwindling community and societal resources. Current evidence points to the strong association between adverse environmental factors and externalizing disorders in children. Although externalizing difficulties in young children are receiving more empirical attention (Campbell, 1995), limited data exist about the development of externalizing difficulties in young children exposed to adverse environmental influences such as poverty.

Head Start, with its emphasis on serving children living in poverty, is an ideal venue for understanding the issues relevant to the emergence of externalizing problems in young, poor children. Because there has been an underestimation of the mental health needs of children in Head Start and a concurrent increase in the level of stress experienced by Head Start children, scholars and practitioners have called for a renewed emphasis on identifying and intervening with children with psychological difficulties.

This exploratory study was undertaken to investigate the prevalence and correlates of psychological difficulties, specifically externalizing behavioral problems in a group of Head Start children. The two phases of the project included: (a) screening all children in five Head Start classrooms for externalizing behavior problems, and (b) an investigation of the characteristics of children who were identified as having externalizing behavior problems.

The initial sample was 156 children registered to enter Head Start (81% of total population

identified). All the children were African American, born in 1991, and lived in homes with incomes below the poverty line. Of the original sample, 40 were identified to participate in the second phase of the study.

Initial assessment of the children and families included a cognitive evaluation of the child using the Peabody Picture Vocabulary Test- Revised (Dunn & Dunn, 1981), a child report of child exposure to violence using the Violence Exposure Questionnaire- Preschool Version (Fox & Leavitt, 1995), a parent report of child exposure to violence using the Survey of Children's Exposure to Violent Events (Fox & Leavitt, 1995), a parent report of child behavior problems using the Child Behavior Checklist (Achenbach, 1991), a parent report of child temperament using the Colorado Child Temperament Inventory (Rowe & Plomin, 1977), a parent psychological functioning using the Brief Symptom Inventory (Derogatis & Spencer, 1982), parent reporting of family functioning using the Family Environment Scale (Moos & Moos, 1981), and parent report of social support using the Personal Resource Questionnaire (Brandt & Weinert, 1981).

Variables regarding classroom behavior assessed in the second phase of the study were: behavioral problems using the Preschool Behavior Questionnaire (Behar & Stringfield, 1974), social competence (La Freniere, Dumas, Capuano, & Dubeau, 1992), and social skills using the Social Problem Solving Test- Revised (Rubin, 1988). Additionally, family factors were assessed using the Parenting Dimensions Inventory (PDI) and the Home Observation for the Measurement of the Environment (HOME; Cladwell & Bradley, 1984).

Initial assessments were conducted in the homes of the study participants. Two interviewers completed each visit; while one interviewed the child, the other interviewed the parent. Each parent was paid $20 for his or her participation and each child was given a small token. The second phase of the study was completed in the school and the home. Classroom behavior and social skills were assessed in the school and family data were collected in the home.

Twenty-six percent of the children were reported by their parents as having externalizing behavioral problems in the borderline clinical range. The relationships between child behavior and the individual family were characterized by correlates of externalizing behavior including family conflict and violence exposure. Eighteen percent of the children exhibited inappropriate behavior as coded by trained observers; children's mean number of behavioral problems as rated by teachers was 13. In terms of social problem-solving skills, 25% of the children utilized aggressive strategies, inappropriate strategies were used 25% of the time, 50% of the sample provided relevant responses to object acquisition questions, and 25% ranked in the upper 50th percentile for flexibility in social problem-solving strategies. Sixty percent of the sample provided at least four different categories of social responses to social dilemmas. Prosocial strategies were also used by 50% of the children in response to social dilemmas involving object acquisition.

Because the results reported are preliminary, no conclusions can be drawn from the data. However, it does seem clear that one fourth of the children in these Head Start sites presented with externalizing behavioral problems, which were related to specific family problems. While these children were ranked as problematic by their parents, they did not for the most part exhibit these externalizing behaviors in school. This may be attributable to the disparity between parent and teacher reports of externalizing behaviors that have been documented previously in the literature (Achenbach, 1991). Additionally, it may be that the Head Start environment provides the structure that children need to facilitate their regulation of impulse and affect that lead to more appropriate behavior. Further analyses of the data will contribute to an increased understanding of this study's children presenting with externalizing behavioral problems.

References

Achenbach, T. (1991). *Manual for the Child Behavior Checklist.* Burlington: Department of Psychiatry, University of Vermont.

Behar, L., & Stringfield, S. (1974). A behavior rating scale for the preschool child. *Developmental Psychology, 10* (5), 601–610.

Brandt, P., & Weinert, C. (1981). The PRQ: A social support measure. *Nursing Research, 30*(5), 227–280.
Caldwell, B., & Bradley, R. (1984). *Home Observation for Measurement of the Environment.* University of Arkansas at Little Rock.
Campbell, S. (1995). Behavior problems in preschool children: A review of recent research. *Journal of Child Psychology and Psychiatry, 36*(1),113–149.
Derogatis, L., & Spencer, P. (1982). *Brief Symptom Inventory: Administration, scoring, and procedures manual- I.* Baltimore, MD: Clinical Psychometric Research.
Dunn, L., & Dunn, P. (1981). *Peabody Picture Vocabulary Test- Revised.* Circle Pines, MN: American Guidance Service.
Fox, N., & Leavitt, L. (1995). *The Violence Exposure Questionnaire for Children (Preschool Version).* College Park: University of Maryland.
LaFraniere, P., Dumas, J, Capuana, F., & Dubeau, D. (1992). Development and validation of the preschool socioaffective profile. *Psychological Assessment, 4,* 442–450.
Moos, R., & Moos, L. (1981). *Family Environmental Scale.* Palo Alto, CA: Consulting Psychologists Press.
Richters, J. Martinez, P., & Valla, J. (1990). *Levonn- a cartoon based measure of children's distress symptoms.* Washington, DC: NIMH.
Rowe, P., & Plomin, R. (1977). Temperament in early childhood. *Journal of Personality Assessment, 41*(2), 150–156.
Rubin, K. (1988). *Social Problem-Solving Test Revised.* University of Waterloo: Canada.

■ Proactive Screening for Young Children With Behavioral Problems: The Early Screening Project (ESP)

Edward G. Feil, Herbert H. Severson, Hill M. Walker

The field of early childhood intervention is predicated on the assumption that problems such as academic failure and behavior problems can be averted with early detection, prevention, and intervention. In order to meet the needs of practitioners, an effective child-find screening system should be accurate, proactive, and cost-effective. In the assessment of young children, the indicators for problem behaviors are evident, but are significantly different from those of the school-age population. Critical factors in the assessment of young children with behavioral problems are: measuring the frequency and intensity of problem behaviors relative to a normative context (either local or national), delineating between externalizing (anti-social) and internalizing (withdrawn) behavioral patterns, utilizing multiple methods (e.g., ratings and direct observations), and gathering information from multiple sources (e.g., teachers and parents). This paper describes the need for and effectiveness of functional screening processes and the Early Screening Project (ESP) assessment system for behavior problems among preschool children aged 3 to 5 years.

The Early Screening Project (ESP) adapted the Systematic Screening for Behavior Disorders (SSBD, Walker & Severson, 1990) for use with 3- to 5-year-old children. The ESP assesses both the frequency and intensity of adjustment problems and allows for cost-effective screening of problem behaviors in order to aid in early intervention and remediation for preschool-age children. The ESP is a three-stage, multiple-gating procedure to screen for behavior disorders among preschool children (see Figure 1).

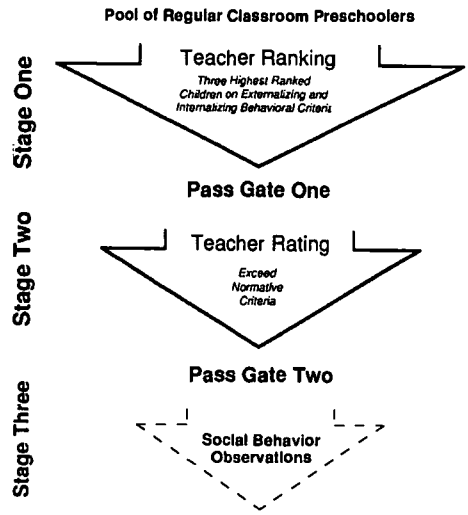


Figure 1. Multiple Gating Procedure Used in the Early Screening Project (ESP).

Stage One was based on teachers' rankings of their students on externalizing and internalizing behavior dimensions. Teachers list the five children who best exemplify a description of externalizing characteristics and five children who best exemplify a description of internalizing characteristics. Then the teachers rank the children on each list, from most characteristic to least characteristic of the externalizing and internalizing dimension.

Stage Two consists of five measures: Critical Events Index, Aggressive Behavior Scale, Social Interaction Scale, Adaptive Behavior Scale, and Maladaptive Behavior Scale. The items comprising these scales are carefully worded in order to facilitate the completion of the ESP by diverse groups of preschool teachers, many of whom have limited experience in student assessment. Items regarding academics are omitted because of their inapplicability to most preschool curricula.

Stage Three measures are based on direct observations of a child's social behavior in the classroom and on the playground. The Social Behavior Observation is a record of the quality, level, and distribution of a child's social behavior within free play settings. Antisocial or nonsocial behavior is defined as: (a) a negative exchange of either verbal of physical interaction, (b) disobeying established classroom rules, (c) tantrumming, and (d) solitary play. The children are each observed for 20 minutes, 10 minutes each on two occasions. In the observation process, the stopwatch runs when the child exhibits antisocial or nonsocial behavior and is turned off when the child displays prosocial behavior. The stopwatch is then restarted when the child exhibits antisocial or nonsocial behavior. The procedure is repeated throughout the observation recording session.

The parent questionnaire has 12 items divided into three scales: (a) Playing with other children, (b) Getting along with caregivers, and (c) Playing with materials and self care. All items are adapted from the ESP Stage Two teacher questionnaires. The first two scales, playing with other children and getting along with caregivers, are stated in positive pro-social, behavioral language and the third scale, playing with materials and self care, is oriented to more problematic child behaviors.

Beginning in 1991, studies on the ESP were conducted to assess its reliability and validity. Good psychometric standards were attained despite the difficulties inherent in the assessment of young children (Martin, 1986). The reliability and validity data show strong results (Feil & Becker, 1993), and 6-month interrater reliability coefficients for Stage Two ESP measures average 79. Validity studies show consistently high relationships to criterion measures such as the Conner's Teacher Rating Scales (Conners, 1990), Preschool Behavior Questionnaire (Behar &

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Stringfield, 1974), and Child Behavior Checklist-Teacher Report Form (Achenbach & Edelbrock, 1986). Correlations resulted in significant coefficients ranging from .34 to .89. The consistency of scores across ESP measures for identified groups of children illustrates the potential utility of the screening system, giving evidence that behavior problems may be identified accurately among preschool children (see Figure 2).

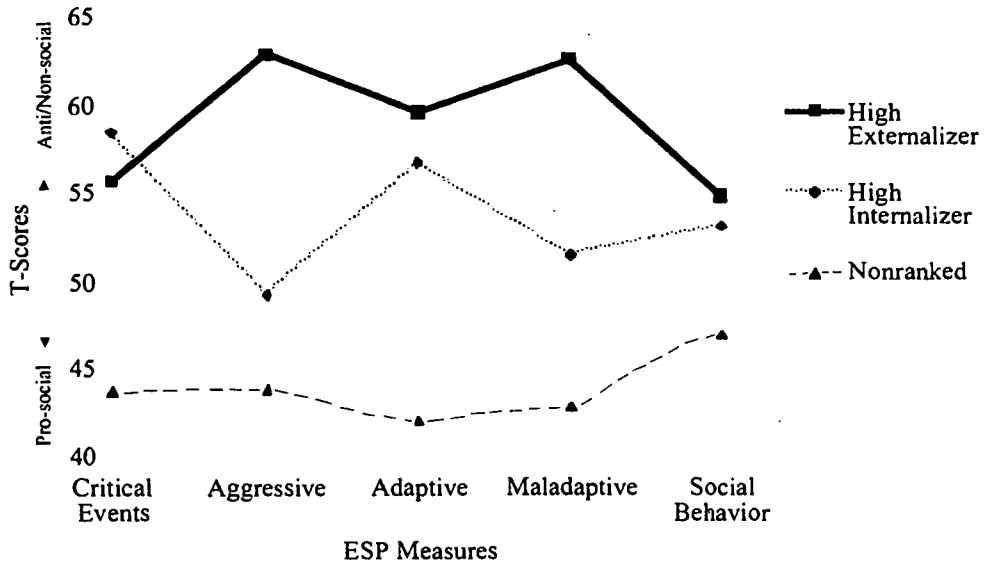


Figure 2. T-Score Means of ESP Measures by High Externalizers, High Internalizers, and Nonranked Groups.

The ESP Stages One and Two procedures can be completed for an entire preschool in a 1.5 hour meeting. Studies have found that multiple gating procedures reduces assessment time and is a cost-effective assessment for behavior disorders (Walker, et al, 1994). The ESP was recently selected as an exemplary procedure in the recent report of the Task Force on Head Start and Mental Health, *Lessons from the Field: Head Start and Mental Health Strategies to Meet Changing Needs* (Yoshikowa & Knitzer, 1997).

The use of multiple methods provides a convergence of information to more accurately assess a child's "true" behavior, and application of a diagnostic criteria can produce reliable diagnostic outcomes. Multiple informants, such as teacher, parent, and observer, contribute unique information about the child's behavior that are superior to a score provided by a single informant (Gresham & Elliot, 1984). The ESP system has been created to utilize the convergent validity across methods, settings, and raters to make valid generalizations. The ESP has been tested in Head Start settings, and can be utilized as part of best-practices for early intervention programs that screen for school adjustment problems for all children in preschool or kindergarten classrooms.

References

Achenbach, T. M., & Edelbrock, C. (1986). *Management for the teacher's report form and teacher version of the child behavioral profile.* Burlington, VT: University of Vermont Department of Psychiatry.

Behar, L. & Stringfield, S. (1974). *Manual for the preschool behavior questionnaire.* Durham, NC: Behar.

Conners, C. K. (1990). *Manual for the Conners' Rating Scales.* North Tonowanda, NY: Multi-Health Systems.

Feil, E. G., Walker, H. M., & Severson, H. H.(in press). Young children with behavior problems: Research and development of the early screening project. *Journal of Emotional and Behavioral Disorders.*

BEST COPY AVAILABLE

Gresham, F. M., & Elliot, S. N. (1984). Assessment and classification of children's social skills: A review of methods and issues. *Preschool Psychology Review*, 13, 292–301.
Martin, R. P. (1986). Assessment of the social and emotional functioning of preschool children. *School Psychology Review*, 15, 216–232.
Walker, H. M. & Severson, H. H. (1990). *Systematic Screening for Behavior Disorders User's Guide and Administration Manual.* Longmont, CO: Sopris West.
Walker, H. M. & Severson, H. H, Nicholson, F., Kehle, T., Jenson, W. R., & Clarke, E. (1994). Replication of the Systematic Screening for Behavior Disorders Procedure (SSBD) for the Identification of At-Risk Children. *Journal of Emotional and Behavioral Disorders*, 2(2): 66–77.
Yoshikowa, H. & Knitzer, J. (1997). *Lessons from the field: Head Start Mental Health strategies to meet changing needs.* New York: National Center for Children in Poverty/ American Orthopsychiatric Association, pp. 5–103.

■ Early Intervention for Behavior Problems in Kindergarten: First Step to Success

Hill M. Walker, Kate Kavanagh, Bruce Stiller, Annemieke Golly, Herbert H. Severson

The presence and social effects of antisocial behavior patterns are being felt pervasively in school districts throughout this country (Larson, 1994; Shanker, 1995; Walker, Horner, Sugai, Bullis, Sprague, Bricker, & Kaufman, 1996). Student aggression, antisocial forms of behavior, adolescent delinquency, vandalism, and interpersonal violence are strongly linked to dimensions of a behavior pattern that children and youth in our schools are adopting in alarming numbers. Given the dramatic and continuing increases evident in US rates of juvenile crime and violence, these estimates may be somewhat conservative and predict a continuing increase in antisocial behavior patterns among adolescents (US Department of Justice, 1995).

First Step to Success (Walker, Kavanagh, Stiller, Golly,Severson, & Feil, 1997) is a collaborative home and school early intervention program for kindergartners at risk for developing antisocial behavior patterns and is designed to prevent and divert at-risk children, at the point of school entry, from a path leading to antisocial behavior (Walker, Horner, et al., 1996). First Step to Success is aimed at helping schools and families work together to teach at-risk, antisocial young children the social behaviors they will need to grow and thrive—particularly within the context of schooling.

The classroom component of First Step to Success uses an early-childhood adaptation of the Contingencies for Learning Academic and Social Skills (CLASS) Program (Hops & Walker, 1988) for acting-out children. CLASS provides a set of procedures, based on social learning principles for improving classroom behavior of primary grade level, acting-out children (K–3). The teacher works with the CLASS program consultant in getting the program operational and implementing it over a period that spans approximately 2 months from start to finish. A classroom consultant is primarily responsible for working with the child and peers in the beginning of the program (consultant phase, lasting 1 week), and over time, the teacher takes over full implementation with consultant support (teacher phase lasting 7 weeks). The preschool adaptation of CLASS has been successfully applied and tested with antisocial kindergartners over the past 2 years (Walker, Kavanaugh, Stiller, Golly, Severson & Feil, in press). This work has been accomplished as part of a 4-year model development grant from the US Office of Special Education Programs.

First Step to Success also includes a parent training component, called HomeBase (Kavanaugh, 1995), in which parents are taught how to work with their child in getting off to a good start in school. The program creates support for a strong home-school partnership. There are six, bi-weekly sessions (of approximately 45 minutes each) with the parents. HomeBase stresses the importance of a collaborative relationship with parents and caregivers. In addition,

the delivery and implementation of HomeBase skills are tailored to meet the family's skill-educational levels and to take into account the stresses and support needs being experienced by the families. Two aspects of HomeBase maximize the family's likely use and acceptance of the HomeBase intervention component. It is delivered to families in their home and the program uses brief games and activities that facilitate parent and child engagement in practice of skills. HomeBase has proven to be highly popular with participating parents.

The First Step to Success program was successfully implemented and evaluated in the Eugene, Oregon 4J School District during the 1993–94 and 1994–95 school years. A total of 46 kindergarten children who were at-risk for antisocial behavior and their teachers, peers, and parents participated in the intervention (24 in year 1 and 22 in year 2). Nearly all participating kindergarten children made significant gains in their social-behavioral and academic adjustments in the kindergarten year. Of the 46 cases, 26% were female, 33% were receiving special education services by the end of the study, 7% were children of minority status, and 37% lived in families with low incomes (i.e., children received reduced or free lunches). A cohort design with experimental and wait-list control groups was used to evaluate intervention effects and to establish a causal relationship between the intervention and resulting changes in child behavior.

Table 1 presents average scale scores and mean Academic Engages Time percentages across four evaluation time points for Cohort 1 students (pre, post, grade 1, grade 2) and three evaluation points for Cohort 2 students (pre, post, grade 1). Inspection of Table 1 indicates substantial average changes, in appropriate directions, for Cohort 1 and 2 students across the five dependant measures from pre to post time points. The effects for Cohort 1 and 2 student groups were closely replicated. Both groups showed acceptable maintenance of achieved intervention effects into first grade with different teachers and peer groups. Cohort 1 also showed moderate maintenance effects into second grade, 2 years following the end of the First Step to Success intervention.

Table 1. Raw Score Treatment and Follow-up Results by Cohort (1993–94 and 1994–95)

	EVALUATION TIME POINTS							
Measures	**Kinder-garten Pre-TX**	**Kinder-garten Post-TX**	**1st Grade Follow-Up**	**2nd Grade Follow-Up**	**Kinder-garten Pre-TX**	**Kinder-garten Post-TX**	**1st Grade Follow-Up**	**2nd Grade Follow-Up**
	1993–94 Cohort				**1994–95 Cohort**			
	(N=24)	**(N=24)**	**(N=20)**	**(N=18)**	**(N=22)**	**(N=22)**	**(N=15)**	
Teacher Ratings of Adaptive Behavior	21.8	28.7	25.5	26.7	21.7	26.7	26.5	—
Teacher Ratings of Maladaptive Behavior	32.6	22.5	23.6	23.8	31.5	26.3	23.7	—
CBC Teacher Report: Aggression Subscale	20.4	11.3	13.8	14.5	24.8	16.8	17.3	—
CBC Teacher Report: Withdrawn Subscale	7.3	5.2	4.4	6.1	4	2.6	1.2	—
Academic Engaged Time Observations	62.4%	82.5%	90.7%	83.1%	59.6%	90.8%	81.8%	—

Table 2 presents analyses of covariance for each of the five dependent measures where baseline or pre-measures were used as a covariate in each analysis. These analyses indicated that four of the five dependant measures were sensitive to the intervention, and they document a causal relationship between student behavior change and the intervention beyond the effect of initial baseline.

Table 2. Analyses of Covariance with Experimental and Wait-List/Control Groups Across Five Dependent Measures

	Baseline Mean (SD)	Post-Intervention (Exp.) or 2nd Baseline (Control) Mean (SD)
Adaptive Teacher Rating Scale		
Experimental	22.68 (5.03)	28.8 (4.19)***
Wait-List/Control	20.83 (4.42)	22.10 (4.93)
F=22.91 (1,45) p<.001		
Maladaptive Teacher Rating Scale		
Experimental	32.40 (6.74)	23.52 (8.70)***
Wait-List/Control	32.17 (7.82)	31.63 (7.03)
F=18.54 (1,45) p<.001		
Teacher Rating on the CBC Aggression Scale		
Experimental	22.24 (10.92)	13.54 (9.33)***
Wait-List/Control	22.00 (11.05)	22.82 (10.04)
F=16.851 (1,44) p<.001		
Teacher Rating on the CBC Withdrawn Subscale		
Experimental	5.00 (3.83)	3.08 (3.39)
Wait-List/Control	6.22 (5.21)	4.45 (4.54)
F=0.23 (1,44) p<.63		
Classroom Observation(s) of Academic Engaged Time		
Experimental	64.00 (10.59)	83.36 (21.09)*
Wait-List/Control	58.78(18.74)	68.18 (20.35)
F=5.65 (1,45) p<.05		

Note: ***p<.001; *p<.05

Measures of aggression are markers for antisocial behavior patterns and for a host of social adjustment problems. Academic Engages Time (AET) is a strong correlate of academic performance and also provides a sensitive measure of a student's ability to meet the academic demands of instructional settings. Normative levels for AET, based upon observational data are considered to be in the range of 75% to 85% when recorded within regular classroom settings (Rich & Ross, 1989). At pre-intervention, Cohort 1 students averaged 62% AET and Cohort 2 students 59% AET; at postintervention these percentages were 82% and 90%, respectively. Producing effects of this magnitude for antisocial children within a school year, which persist from kindergarten into first grade, is a relatively rare occurrence in the available empirical literature (Reid, 1993). These results provide support for the efficiency, cost-effectiveness, and promise of First Step to Success as a model early intervention approach that may divert at-risk kindergartners from experiencing a host of long-term, negative developmental outcomes.

References

Hops, H. & Walker, H. M. (1988). *CLASS: Contingencies for Learning Academic and Social Skills.* Seattle, WA: Education Achievement Systems.

Kavanaugh, K. (1995). *The HomeBase parent training program: A component of the First Steps.* Eugene, OR: Oregon Social Learning Center.

Larson, J. (1994). Violence prevention in schools: A review of selected programs and procedures. *School Psychology Review,* 23(2), 151–164.

Reid, J. B. (1993). Prevention of conduct disorder before and after school entry: Relating interventions to developmental findings. *Development and Psychopathology, 5.* 243–262.

Rich, H., & Ross, S. (1989). Students' time on learning tasks in special education. *Exceptional*

Children, 55(6): 508–515.
Shanker, A. (1995). Classrooms held hostage: The disruption of the many by the few. *American Educator*, 19(1): 8, 13, &47.
U.S. Department of Justice (1995). *Federal Bureau of Investigation crime in the United States.* Washington, DC, Federal Bureau of Investigation annual.
Walker, H. M., Horner, R., Sugai, G., Bullis, M., Sprague, J., Bricker, D., & Kauffman, M. (1996). Integrated approaches to preventing antisocial behavior patterns among school-age children and youth. *Journal of Emotional and Behavioral Disorders*, 4(4): 194–209.
Walker, H. M., Kavanaugh, K., Stiller, B., Golly, A., Severson, H.H., & Feil, E.G. (in press). The First Steps early intervention program for at-risk kindergartners: Rationale, procedure, and outcomes. *Journal of Emotional and Behavior Disorders.*
Walker, H. M., Kavanaugh, K., Stiller, B., Golly, A., Severson, H. H., & Feil, E. G. (1997). *First Step to Success.* Longmont, CO: Sopris West Publishing.

Health, Normative Development, and Contextual Transitions in Minority Children

CHAIR: Gontran Lamberty
PRESENTERS: Suezanne T. Orr, Robert Needlman, Odette Alarcón, Maureen Black, Joanne E. Roberts, Frances A. Campbell

Several reviews of minority health and developmental research conducted in the late 1980s and early 1990s indicated a pattern of omission and neglect. Specifically, the reviews showed (a) a conspicuous absence of investigations on the health and development of minority mothers and children, (b) an emphasis on outcomes rather than on process in what little research was being done, (c) a tendency to assess the experience of minority groups using White mainstream groups as the standard of comparison, (d) a disregard for the diversity inherent in some minority group categories (i.e., Latinos, Asians), and (e) a minimization of the effects of such social structure derivatives as racism, residential segregation, prejudice, and discrimination on the health and development of minority children.

Based on the above considerations, the Maternal and Child Health Bureau (MCHB) in 1992 decided to make the support of research on the health and development of minority children a priority of the 1990 decade, and, within that priority, to focus on minority group-specific rather than on minority-mainstream comparative studies. The Bureau viewed the emphasis on comparisons between minorities and the mainstream as being problematic in one important respect: it hampered the development of a minority group-specific knowledge base that is crucial for the design of effective and culturally competent MCH program interventions.

The six presentations comprising this symposium are based on studies that have three characteristics in common. First, they are minority-group specific. Second, they have a multidisciplinary orientation in content as well as in study design and methodology. Third, the conceptual frameworks driving the studies are based on multifactorial models of causation which take into consideration such factors as maternal and infant characteristics, the quantity and quality of the medical care received, as well as the physical and the social ecologies in which minority mothers, fathers, and children play out their lives.

While they are different in the type of research genre they represent (one is observational while the other is experimental), and in the research questions they pose, the first two presentations are concerned with what influences health supervision during the first years of life. Orr's investigation seeks to assess the relationship between mother's exposure to stressors, depressive symptoms, use of prenatal care, and mothers' use of well-child care for their 2-year-old children. Needlman's study aims to evaluate the efficacy of a pediatric health supervision intervention specifically designed to promote literacy in children during routine well-child supervision visits. The intervention study exemplifies a growing trend toward fusing child development and child health considerations in studies of early childhood.

The third and fourth presentations by Alarcón and Black are concerned with the normative development of two important groups of minority children: African Americans and mainland Puerto Ricans. These two studies are important for three reasons. First, for most indicators of development, health, and social well-being, these two groups occupy the most unfavorable positions in comparison to other minority groups. Second, the studies have an orientation toward understanding the strengths of these children and their families rather than their deficits. Third, in pioneer fashion these studies seek to explore the effects of racism on normative development. In doing so, the studies promise to make significant contributions to the measurement and demystifying of the construct.

While important in ecologically-driven theories of child development, contextual and developmental transitions have not fared well as topics of research. The fifth and sixth study presentations by Roberts and Campbell are welcomed additions. Robert's study focuses on low-

socioeconomic status African American children from a diversity of ecologic backgrounds who are transitioning from early child care to elementary school. Such children constitute a profoundly disadvantaged subset of US children, with increased risk for a broad variety of suboptimal developmental, behavioral, academic, and social outcomes. The study is based on a conceptual framework that emphasizes transactions between child risk factors and multilevel environmental risk factors as the principal determinants of developmental trajectories.

Campbell's investigation aims to identify the ecological, personal, and situational factors associated with young adult (age 21) outcomes in a group of African American children who participated in the Abecedarian Project, a randomized clinical trial of early childhood educational intervention. The study provides a unique multigenerational perspective on the effects of extensive family support (education, child care, and free pediatric care in early childhood years) on the later life success of African American children from low-income families and their parents.

■ Maternal Psychosocial Factors and Use of Well-Child Care

Suezanne T. Orr

There is consensus among the medical, public health, and public policy communities that preventive health care is of great importance to infants and preschool-age children. Despite this, many children, especially those of lower socioeconomic status, or members of minority groups, do not receive recommended levels of preventive care and immunizations in the preschool period.

A beneficial approach to increasing use of preventive care by young children may be to focus upon early identification of infants who are at increased risk of subsequent lack of adequate preventive care and immunizations. Specific factors associated with poor health care outcomes among children from low-income families may serve as signals for early identification of those infants and children who would most benefit from special efforts to involve them in preventive care.

There is reason to believe that selected maternal psychosocial factors and use of prenatal care may be associated with subsequent participation in preventive health care by young children. The maternal psychosocial factors include maternal exposure to stressors and depressive symptoms. By examining the relationship between these psychosocial factors, as well as maternal use of prenatal care, it may be possible to develop interventions targeted at specific high-risk populations of mothers and children to increase the use of preventive care among young children.

The objective of this research was to evaluate the associations between maternal exposure to stressors, depressive symptoms, and use of prenatal care with use of well-child care and immunizations in the first 2 years of life.

The data for this study were derived in part from a prior longitudinal study of maternal psychosocial factors and pregnancy outcomes. Women were enrolled in the prior study at several hospital-based prenatal clinics, and, at enrollment, completed a baseline questionnaire about psychosocial factors, including depressive symptoms and exposure to stressors. For the current study, women who enrolled at one of the sites were located and interviewed by telephone about sources of pediatric care used by the infants during the first 2 years of life. Subsequently, the pediatric records of each child were reviewed to obtain information about use of well-child care and immunizations during the first 2 years of life.

Overall, 87.9% of the infants were up-to-date on immunizations at 12 months and 52.6% were up-to-date on well-child visits at 12 months. The median number of well-child visits in the

1st year of life for the children in the sample was five. At 24 months of age, 74% were up-to-date on immunizations and 48.6% on visits.

The majority of children (82.9%) had only a pediatric provider in the 1st year of life. About half of the children used a large hospital-based primary care center with a long-standing interest in promoting appropriate use of well-child care. Fewer than 2% of the children had no source of pediatric care.

None of the independent variables of interest (i.e., maternal exposure to stressors, depressive symptoms, or trimester of enrollment in prenatal care) were associated with any of the dependent variables. However, maternal prenatal behaviors were associated with use of well-child care during the first 2 years of life. Smoking, for example, was associated with being up-to-date on visits at 12 to 24 months of age.

These results suggest that certain maternal behaviors, such as smoking and drug use during pregnancy, are significantly associated with lack of completion of recommended well-child care and immunizations during the 1st year of life.

Completion of recommended immunizations and well-child care in this sample of children is higher than in many samples. Since the sample of children is primarily of lower socioeconomic status and African American, we would expect the level of immunizations to be much lower. The high use of well-child care and immunizations is due in part to the high level of enrollment in pediatric primary care by the children in the sample.

■ Pediatric Health Supervision to Promote Literacy

Robert Needlman

Pediatricians have a special opportunity to promote reading aloud among parents of young children through the frequency of health supervision visits, the typically long waiting room times, and the one-to-one interchange with parents during the visit. Pediatric intervention to promote literacy, as a form of primary intervention, typically includes three components: (a) waiting room readers who model reading aloud for parents, (b) anticipatory guidance about literacy as part of health supervision, and (c) distribution of free, developmentally and culturally appropriate books at each visit beginning at 6 months. This model has been replicated nationwide and has been adopted as the centerpiece of the First Lady's Prescription for Reading Partnership.

Although six studies have documented the effectiveness of this model, all have methodological weaknesses, including retrospective designs, the use of historical controls, and reliance on parent self-reported behaviors. The present study is a prospective, randomized study designed to provide a methodologically rigorous assessment of the intervention.

Parents who brought their infants for 4-month checkups at an urban pediatric primary care clinic were consecutively enrolled over 12 months. Following baseline interviews and assessment of maternal vocabulary and reading ability, the dyads were randomized to receive either books (the "book" group) or toys (the "toy" group) at each regularly scheduled visit. Pediatric residents, nurse practitioners, and attending pediatricians delivered the interventions. There was no waiting room component.

Parents were interviewed quarterly throughout the study using open-ended questions to avoid social desirability responding. Child language was tested at 2 years and 3½ years using the Preschool Language Scale (PLS), the Peabody Picture Vocabulary Test (PPVT), and the Expressive One-Word Picture Vocabulary Test (EOWPVT).

Three hundred mothers and their children were enrolled. The sample was predominantly US born (97%), English speaking (98%), and African American (95%). Although 70% were high school graduates, mean age-corrected scores on standardized tests of reading (WRAT) and verbal

vocabulary (PPVT) were 57.6 and 73.7, respectively (test mean 100, SD 15.) Interviewed at baseline (average age 5 months), 8% included reading aloud as a favorite parenting activity, 51% included reading as promoting later school success, 44% reported owning no children's books, and 11% reported more than 10. Belief in the educational value of reading aloud was associated with both reading aloud as a favorite activity (adjusted odds ratio 5.5, $p<.004$ by logistic regression) and book ownership ($F=13.2$, $p<.003$) after controlling for potential confounding factors. In contrast, maternal grade attainment was not significantly associated with either reading aloud as a favorite activity or book ownership.

The randomization generated comparable groups. Parents in the book group reported book use as one of their baby's favorite activities in 23% of follow-up interviews versus 17% among the toy group, $p<.04$. The groups did not differ in frequency of book use as reported in the 24-hour activity recalls. At 25 months and 43 months, no significant group differences were found in expressive or receptive language. Analyses of videotaped reading sessions shall be completed.

The study demonstrates conclusively that brief pediatric intervention can positively influence parental beliefs about reading aloud to their young infants. Several design features may have limited its ability to detect differences in behaviors and language scores: (a) There was no waiting room program; (b) Interventions were given by more than 60 different practitioners, many of whom were inexperienced; (c) Few children received a full "dose" of intervention; (d) The open-ended question format, adopted to limit social desirability, may have been relatively insensitive to changes in parental behaviors; and (e) The toy control may have influenced child language development. Future studies will need to address these potential biases, incorporating the full Reach Out and Read model (including waiting room readers) and utilizing experienced clinician interviewers, with longer follow-up and more continuous intervention if possible.

■ A Culturally Sensitive Longitudinal Study on Health and Development of Puerto Rican Children

Odette Alarcón, Sumru Erkut, Cynthia García Coll, Jacqueline Fields

This longitudinal study of the healthy development of 250 Puerto Rican children living on the U.S. mainland was carried out by a multidisciplinary team of researchers. The data were gathered through face-to-face interviews with the children and their primary caregivers. The components of healthy development that were examined include physical health, self-esteem, ethnic identity, and behavioral adjustment.

The research is grounded in a cultural-ecological framework following Ogbu and Bronfenbrenner. Special emphasis was placed on the influence of racism and discrimination on the healthy development of children. Child variables of interest were subjective perception of skin color, ethnic identity, and self-esteem. Family variables of interest were migration history, parents' job stress, parental depression, and anxiety. It is important to stress that the study focused on the healthy development of Puerto Rican children with a normative and not a deficit model. An initial sample of 291 families was recruited. Our attrition rate has been 7% per wave; thus 260 children completed the study.

Questionnaires were created in English and in Spanish. The final survey instruments were a composite of existing measures, instruments that were modified extensively to make them culturally synthonic, and new measures developed for this study. Important measures developed for this study were The Color of My Skin, Self-Esteem, and Ethnic Identity and Discrimination. The newly developed "dual focus" technique was utilized in translating and creating new measures.

Interesting demographic findings are:

1. Forty percent of the children in the study were first born.
2. The majority of the mothers are in their 20s and have a high school education.
3. Regarding health and care, 68.7% of the children are taken care of by the mother, 67.5% have government insurance, and 22.9% have private insurance. All children receive routine health care and vaccines. Contrary to common beliefs, these children are well taken care of and parents make use of available resources.
4. Regarding mothers' health, they have a low depression index, low anxiety, and good coping skills. The children's physical health indexes resemble those reported by the Department of Public Health.
5. Regarding mental health, 10.6% of the children had a mental health problem that lasted more than 3 months; of these, only half received help.
6. Our new measures showed that children preferred to have a lighter skin color and were aware of the preference of society for lighter color.
7. Eighty-eight percent identified as Puerto Rican, their choice of label relating to their place of birth, the language spoken by the parents, and the language the child spoke with siblings.
8. Twelve percent had experienced discrimination. Their self-esteem is 4.5 on a Likert-type scale from 1 to 5.
9. Although children are aware of the preference of light skin in society and of their own preference for lighter skin color, when we compared their self-esteem, the report of the color of their skin, and their ethnic identity, we found no significant difference in self-esteem associated with skin color, satisfaction with skin color, ethnic identity, or experience with discrimination.

References

Alarcón, O., Erkut, S., García Coll, C., & Vazquez García, H. (1994). *Engaging in culturally sensitive research on Puerto Rican youth.* Working paper #275. Wellesley, MA: Wellesley College Center for Research on Women.

Alarcón, O., Erkut, S., Szalacha, L., García Coll, C., Fields, J., & Gonzalez, S. (1998). *The color of my skin: An index to measure children's awareness of their skin color and satisfaction with it.* Working paper #288. Wellesley, MA: Wellesley College Center for Research on Women.

Bronfenbrenner, U. (1988). Forward. In A. R. Pence (Ed.), *Ecological Research with Children and Families.* New York: Teachers College Press.

Erkut, S., Alarcón, O., García Coll, C., Tropp, L. R., & Vazquez García, H. A. (in press.) The dual-focus approach to creating bilingual measures. *Journal of Cross Cultural Psychology.*

García Coll, C., Lamberty, G., Jenkins, R., McAdoo, H. P., Crnic, K., Wasik, B. H., & Vazquez García, H. (1996). An integrative model for the study of developmental competencies in minority children. *Child Development, 67,* 1891–1914.

Ogbu, J. V. (1981). Origins of Human Competence: A Cultural-Ecological Perspective. *Child Development, 52,* 413–429.

■ Multivariate Hierarchical Longitudinal Models of Height and Weight for Children With and Without Early Growth Deficiency: Follow-Up at Age 6

Maureen M. Black, Ambika Krishnakumar

Growth deficiency or failure to thrive (FTT) is a relatively common problem among low-income infants and toddlers. Little is known about catch-up or physical growth patterns of children

living in poverty. The objectives of this investigation were to examine genetic and contextual factors associated with longitudinal changes in weight and height through age 6 among a sample of low-income, predominantly African American children.

This investigation is part of an ongoing longitudinal study of the growth and development of low-income children raised in inner-city Baltimore. Two hundred and twenty-five children, the majority of whom were African American (92%) and who had few financial resources, took part in the study. Most mothers were young (M=22.9 years), had limited education (M=11.0 years of school), and were not married (89%).

All children were healthy and full term at birth, but some (127/225) experienced FTT in the first 2 years of life. Children in the FTT and the comparison groups did not differ on most sociodemographic characteristics. However, parents of children in the comparison group were taller and mothers had more years of schooling. The mothers of children in the comparison group were more nurturing, but perceived their children's health at a lower level than mothers of FTT children.

Children were measured for height and weight at eight time points from baseline to age 6. At baseline (child age < 25 months), children in the comparison group were taller and heavier than the FTT group. By age 6, children in the FTT group had made significant improvement in their growth, but continued to lag behind children in the comparison group in height and weight. The number of children in the FTT groups who were stunted and/or wasted at baseline was reduced significantly from baseline to age 6 (18% to 3% and 31% to 3%, respectively). Thus, at baseline and at age 6, children in the FTT group were lower in weight and height than children in the comparison group.

To test the rate of acceleration in height and weight for both groups, hierarchical models were used. Genetic and contextual factors that could alter or enhance the rate of change in growth patterns were introduced in the models.

Height and weight was stronger for the comparison group than the FTT group, suggesting that early FTT has long-lasting effects on children's growth. Results indicated that for both groups, height acceleration was associated with taller parents, older mothers, recruitment into the study at younger ages, and female gender. Weight acceleration for both groups was associated with taller parents, heavier mothers, younger age at recruitment, and maternal perception of health. The association between maternal perception of health and rate of change in child's weight was stronger for children in the comparison group than in the FTT group. It appears that mothers in the comparison group who viewed their children as healthy had children who gained weight at an accelerated rate, suggesting that maternal perception of child health and child's weight gain were concordant. On the other hand, mothers in the FTT group may view their children as healthy, despite their children's inability to gain weight as rapidly as the comparison group.

Distal factors, such as indices of poverty, played no role within this relatively homogenous sample of children from low-income, urban communities. Thus, interventions that help mothers restructure their perceptions of their children's health may lead to environments that are more conducive to healthy growth.

■ African American Children's Transition to School: Role of Child, Family, and Child Care Factors

Joanne E. Roberts, Donna M. Bryant, Margaret Burchinal, Sandra Jackson, Susan Zeisel

The purpose of this study is to examine how risk and protective factors within a child (e.g., children's language skills), family (e.g., responsiveness and support of the home environment), and community (e.g., quality of child care) during the first 5 years of life influence children's transition to school during the early elementary school years.

Seventy-four African American children whose development, home, and child care environments have been prospectively documented since infancy are participating in the study. Children entered the study between 6 and 12 months of age and were recruited from nine community child care programs in two small southern cities. Upon entry into the study, two thirds of the children were from families living below the poverty level, with 29% of their mothers' terminal degree less than high school and 29% at the high school level. Children currently range in age from 6 to 8 years, with 36 children having completed kindergarten, 30 children first grade, and 8 children second grade.

During the first 5 years of life, children's middle ear and hearing status was documented repeatedly and language and cognitive development, quality of the child care environment, and the responsiveness and support of the home environment assessed annually. Measures of the child (e.g., letter word identification), school (e.g., teachers' ratings of child's academic competence), family (parents' perception of school), and classroom (e.g., curriculum observations) were collected prior to entry into kindergarten and at the end of kindergarten.

Preschool Results: We have previously reported that the responsiveness and support of the home environment mediates the association between a history of otitis media with effusion (OME) and language and cognitive skills in infancy (Roberts, Burchinal, Medley, Zeisel, Mundy, Roush, Hooper, Bryant, & Henderson, 1995; Roberts, Burchinal, Henderson, Hooper, Roush, Bryant, Mundy, & Zeisel, in press). Further, the responsiveness and support of the home environment and the child care environments predicted children's language development during the preschool years (Burchinal, Roberts, Nabors, & Bryant, 1996; Burchinal, Roberts, Riggins, Zeisel, Neebe, & Bryant, in press; Roberts, Burchinal, & Durham, in press).

School-Age Entry and Kindergarten Results: The quality of child care during the first 5 years of life continued to predict children's receptive vocabulary at school-age entry. The responsiveness and support of the home environment during infancy and preschool also correlated positively with measures of receptive and expressive language, letter-word identification, and applied math problems at entry into school. At the end of kindergarten, measures of the home environment also predicted receptive vocabulary. Children who had higher language skills during the preschool years continued to score higher on measures of language at the end of kindergarten and were rated higher by their teachers in academic competence at the end of kindergarten. There was a direct, although very mild, association between OME during the first 5 years and later expressive language and math skills at entry into school. However, the home and child care environments were more strongly related to these outcomes than OME.

In summary, these data provide support for the role of the responsiveness and support of the home environment and the quality of the child care environment on African American children's successful transition into school.

References

Burchinal, M. R., Roberts, J. E., Nabors, L., & Bryant D. M. (1996). Quality of center infant care and infant cognitive, language, and social development. *Child Development, 67*(2), 606–620.

Burchinal, M. R., Roberts, J. E., Riggins, R., Zeisel, S. A., Neebe, E., & Bryant, D. (in press). Relating quality of center child care to early cognitive and language development longitudinally. *Child Development.*

Roberts, J. E., Burchinal, M., & Durham, M. (in press). Parents' report of vocabulary and grammatical development of African American preschoolers: Child and environmental associations. *Child Development.*

Roberts, J. E., Burchinal, M. R., Henderson, F. W., Hooper, S. R., Roush, J., Bryant, D., Mundy, M., & Zeisel, S. (in press). Otitis media and maternal responsiveness in relation to children's language at two years. *Pediatrics.*

Roberts, J. E., Burchinal, M., Medley, L. P., Zeisel, S. A., Mundy, M., Roush, J., Hooper, S., Bryant, D., & Henderson, F. W. (1995). Otitis media, hearing sensitivity, and maternal responsivness in relation to language during infancy. *The Journal of Pediatrics, 126*(3), 481–489.

■ The Role of Early Family Supports in Adult Self-Sufficiency

Frances A. Campbell, Craig T. Ramey

This study is a longitudinal, multigenerational examination of outcomes of the Abecedarian Project, a randomized clinical trial of early intervention for children from low-income families. Participants were 109 mothers and their 111 children (98% African American). Fifty-seven infants were assigned to preschool treatment and 54 were controls. All children were at risk for suboptimal development and academic failure because of poverty (Ramey, MacPhee, &Yeates, 1982).

Preschool treatment was 5 years of early education in a full-time child care setting, with primary pediatric care included. Evaluations showed that treated preschoolers had significantly higher IQ scores and were less likely to score in the retarded range (Ramey & Campbell, 1984). Teenaged mothers of treated children made greater educational gains and were better able to parent; this benefit was less striking for older mothers (Campbell, Breitmayer, & Ramey, 1986).

At school entry (age 5), the preschool groups were re-randomized; half of each had educational support during the primary grades (K–2). Home School Resource Teachers created individualized home learning activities for treated children, consulted with classroom teachers, and assisted their families to secure basic resources and services, as needed. At the treatment endpoint, children's academic test scores (reading and math) increased as a linear function of the number of years of early treatment (Ramey & Campbell, 1991).

Follow-up child IQ and academic data were collected at ages 12 and 15, with parental educational levels and life success assessed to the same points. Through age 15, higher scores on academic achievement, lower rates of grade retention, and fewer placements into special education were consistently seen in treated children (Campbell & Ramey, 1994; 1995). Teenaged mothers continued to show greater educational gains if their children had early child care.

The funded research represents a young adult follow-up of the individuals who were enrolled as children (now aged 21 years) and their mothers. Parent ages will range from the 30s to 60s. Assuming full recruitment, 105 of the original 111 persons and 103 mothers (or surrogates) may be included. An ecological model guides the study, relating outcomes in both generations to early and continued community, family, and individual differences along with early childhood treatment in both phases.

Young adults will have direct assessments of IQ and academic achievement, supplemented by searches of school records and public records of delinquency and crime. Both parents and young adults will describe their educational and vocational accomplishments. All will complete measures of self-concept, locus of control, environmental stressors, mental health status, and risk-taking behaviors. Data collectors will be blind to subjects' previous treatment history and developmental progress.

Analyses will test primary hypotheses about the long-term correlates of early educational intervention and will evaluate interactions among individual, family, and community-level influences on development. The findings are relevant to priority areas involving the growth and development of minority children living in poverty.

Data collected at this point, informed by an extensive longitudinal database, contain important answers concerning ecological, personal, and situational factors associated with different developmental trajectories (e. g., Campbell, Helms, Sparling, & Ramey, 1998; Burchinal, Campbell, Bryant, Wasik, & Ramey, 1997).

References

Burchinal, M. R., Campbell, F. A., Bryant, D. M., Wasik, B. M., & Ramey, C. T. (1997). Early intervention and mediating processes in intellectual development among low-income African American children. *Child Development, 68*, 935–954.

Campbell, F. A., & Ramey, C. T. (1994). Effects of early intervention on intellectual and academic achievement: A follow-up study of children from low-income families. *Child Development, 65,* 684–698.

Campbell, F. A., & Ramey, C. T. (1995). Cognitive and school outcomes for high-risk African American students at middle adolescence: Positive effects of early intervention. *American Educational Research Journal, 32*(4), 743–772.

Campbell, F. A., Breitmayer, B. J., & Ramey, C. T. (1986). Disadvantaged teenage mothers and their children: Consequences of educational day care. *Family Relations, 35,* 63–68.

Campbell, F. A., Helms, R., Sparling, J. J., & Ramey, C. T. (1998). Early childhood programs and success in school: The Abecedarian study. In W. S. Barnette & S. S. Boocock (Eds.), *Early care and education for children in poverty: Promises, programs, and long-term effects* (pp. 145–166). Albany, NY: State University of New York Press.

Ramey, C. T., & Campbell, F. A. (1984). Preventive education for high-risk children: Cognitive consequences of the Carolina Abecedarian Project. *Special Issue: American Journal of Mental Deficiency, 88*(5), 515–523.

Ramey, C. T., & Campbell, F. A. (1991). Poverty, early childhood education, and academic competence: The Abecedarian experiment. In A. Houston (Ed.), *Children in poverty: Child development and public policy* (pp. 190–221). New York: Cambridge University Press.

Ramey, C. T., MacPhee, D., & Yeates, K. (1982). Preventing developmental retardation: A general systems model. In A. Bond & J. M. Joffe, (Eds.), *Facilitating infant and early childhood development* (pp. 348–401). Hanover, NH: University Press of New England.

Children With Special Health Care Needs

CO-CHAIRS: Mireille B. Kanda, John M. Pascoe
DISCUSSANT: Nancy Sheppard
PRESENTERS: George Isham, Joan M. Patterson, Tom Tonniges

John Pascoe: I would like to introduce our speakers for the Children with Special Health Care Needs symposium. Joan Patterson is an associate professor and chair of maternal and child health and a family psychologist at the School of Public Health at the University of Minnesota in Minneapolis. She is also director of research for the Center of Children with Chronic Illness and Disability within the Department of Pediatrics. Her focus today will be on the families of children with special health care needs and the stresses and strains with which they must cope. Tom Tonniges is director of the Department of Community Pediatrics at the American Academy of Pediatrics where he oversees programs that directly influence the health and care of children and their communities. He will share his pediatric perspective, specifically focusing on the medical home program. George Isham is medical director and chief health officer at Health Partners in Minneapolis. He will share his systems perspective, which goes beyond managed care. Nancy Sheppard has a background in health education and is a health specialist at Higher Horizons Head Start in Fairfax County, Virginia. She will discuss the presentations from the Head Start perspective.

Mireille Kanda: The Head Start Bureau is pleased to have a discussion about these issues, which are so important to the Bureau. Head Start has served children with disabilities and special health care needs from its conception. Indeed, our performance standards reflect that commitment. The revised performance standards, which came into effect on January 1st, 1998, further the commitment of Head Start programs to children with special needs. Programs are now mandated to offer 10% of their enrollment for children with disabilities.

Furthermore, the development of our relatively new initiative, Early Head Start, now extends the services of Head Start to pregnant women, infants, and toddlers. As we look at the issues of children with special health care needs, particularly where issues of disabilities and policy are concerned, it is important that we look at collaboration.

Although Head Start has provided services to 60 million preschoolers, infants, and toddlers over the last 3 decades, we certainly realize that we cannot do it alone. It is not possible from a funding viewpoint nor is it feasible from an expertise viewpoint. We welcome the collaboration that we are seeing exemplified in this presentation. When we are all done and return to our respective settings, we want to continue the conversation.

Joan Patterson: What I am going to talk about today, I learned primarily from the families of children with chronic illnesses and disabilities that I have been studying. I want to acknowledge that and thank them for all that they have taught me. Children with special health care needs live in families like yours and mine. Most have desires and aspirations that are similar to other families in their social position. Yet, having a child with a disability or a chronic illness changes many things for them. They face a host of added strains in their lives, such as the ongoing special care needs of the child. Many times there are significant changes in the family's life course due to having a child with special health care needs. There is often a need to change family roles and routines and reorganize. There is often less time for other family members, which is a source of worry for many parents. In addition, they sometimes experience strains outside the family, like the loss of supportive networks and the social stigma of disability.

Of course they often experience added financial costs related to their child's special needs and have problems accessing needed health care services, special education services, and some social services. Once they have accessed those services, they often experience problems assuring that

the quality of those services is maintained. Uncertainty regarding payment for these services is probably the biggest source of strain that we hear from these families over and over again as the payer systems continue to change. They worry about the future and who is going to care for their child as they age and as the child ages.

All of these strains pile up for these families. In addition to the strains related to the child's special health care needs, they experience the strains that are common to all families. This takes its toll on families over time. The good news is that families learn to develop the capabilities, resources, and coping behaviors for managing stress. There is a range of resources within the family, such as income, self-esteem, and family cohesion as well as resources in the community, such as health care services and friends. In addition, they often develop new coping behaviors for managing demands. There is a balance between the sources of demand in their lives and how they manage them. When they are able to accomplish this balance, they do very well.

Even though families of children with special health care needs have an unusually high level of demands, many of them do achieve this kind of balance. We talk about the resilience of these families. Many of you are familiar with the concept of resilience, which is very popular in the human development literature in general and youth development literature in particular. Part of what helps these families achieve a balance is the way they give meaning not only to the situation of having a child with special health care needs, but also to who they are as a family and their view of the world.

I do not want to leave the impression that all families of children with chronic illnesses and disabilities are resilient and achieve balance. Sometimes things get out of control when the demands pile up beyond their capacity to deal with them. This is what we refer to in family stress theory as a crisis. It is a period of extreme disorganization and disruption in the family. Many times when families seek help from professional providers of services, they are experiencing this kind of disruptive crisis. We need to be very careful as service providers not to label families that we see during these times as dysfunctional, because, in many instances, they are in a temporary state and eventually do restore balance. In fact, there is a theoretical model called the family adjustment and adaptation response model, which is the orientation we are using in our research to understand how families adapt to a child's chronic health condition. Even though these families sometimes do get into a crisis when the demands pile up, they are in most instances able to restore balance and achieve a level of adaptation.

Another area we are researching is the child's ability to accomplish developmental tasks, such as developing the capacity for empathy, emotional regulation, and problem-solving ability. We are also interested in how other family members are functioning in their important life roles. Additionally, we are interested in the family unit and the degree to which it is able to maintain morale and commitment even in the face of recurrent stress. Finally, we are interested in the degree to which the family as a unit can fulfill its primary functions of membership, nurturance, and economic support.

I want to shift now to the processes by which families become overloaded with stress and, conversely, the four protective processes by which families successfully manage stress. We are moving in this direction in our research because of the need to go beyond the identification of risk and protective factors and understand more about the mechanisms and the processes by which these factors come into play. This has been emphasized by a number of resilience researchers, particularly Michael Rudder.

Let me start with the first kind of risk process that we observed in families. Much of this comes from a current, longitudinal study of about 250 children with chronic illnesses and disabilities. There are two age cohorts: (a) a younger group of children who were 6 to 18 months old when we began the study about 6 years ago, and (b) an older group of children who were 8 to 10 years old when we began the study. By following these families over time, we are able to understand more about these mechanisms and processes. One of the risks faced by these families is the risk of becoming socially isolated. It seems to be mediated by the added demands

that they have on their time, which can preclude their involvement in social activities. This feeling of social isolation is often exacerbated because some of their friends and even relatives pull away.

We were surprised to learn that the families in our study often talked about sources of nonsupport. When we asked them about support, they opted to tell us about the times when people were not supportive, particularly within their prior social networks. The other major source of nonsupport or insensitivity was among some health care providers, particularly in the group of younger children. As the children got older, there was more discussion of educational providers not being sensitive to or supportive of the family. There are often conflicts with service providers and particularly with the payers of services. In addition, they worry about the well-being of other family members. Finally, the exhaustion coming from trying to manage all these sources of stress in their lives, including the burden of providing home care given the loss of support networks, can often lead to a compromise in the health of caregivers.

A few years ago, we did a study of 60 families with a medically fragile child living at home. These are children that require ongoing care or professional services to sustain life, so they are at the high end of severity in terms of chronic illness and disability. We found that in 75% of the families, one or both parents scored in the psychiatric case range on a symptom inventory, that is, a significantly high level of distress to sustain over a long period of time while adequately fulfilling other important roles as parents and caregivers. It is getting more difficult for families to deal with the conflicts of service delivery systems. This is related, of course, to changes in how health services are organized and delivered. There is considerable tension and uncertainty for these families in terms of whether they will be able to access high-quality services for their children over a sustained period of time.

This tension can lead to child-rearing problems. If the caregiving burden is too high, the caregiver can experience exhaustion or depression and may become more socially isolated, which can be associated with less effective parenting. Some of these pathways are known to be strong, such as the pathway between depression and ineffective caregiving, and can lead to certain problems in one or more family members. This does not always happen, but I am trying to explain the dynamic nature of how these processes can unfold and, more importantly, discuss places where we might intervene to help prevent negative outcomes.

Now I want to shift to understanding how families do well in the face of living with the chronic strain of special health care needs, which was the goal of our longitudinal study, Project Resilience. I am pleased to say that the families in our sample are doing very well, often scoring higher on some of the standardized scales of family and child functioning than children and families without chronic illness and disability. That is the incredible beauty of stress; it can actually stimulate growth and development if families have sufficient resource capabilities to master the added set of demands. Providing sufficient resources is the crucial part for us to remember, particularly when we think about policies. Families do not automatically have everything they need.

One of the protective processes observed is an increase in families' level of mastery as they acquire more knowledge about their child's condition. They often teach their child's physician something he or she did not know. Because there are so many different kinds of chronic illness conditions, physicians are not always able to investigate in as much detail as families. Families also develop a sense of mastery because they often learn highly technical skills in providing services to their children. They also learn how to "work the system"—the health care system and the educational system—in trying to figure out the best way to access what they need. They also develop this sense of mastery by becoming very strong and effective advocates for all children with special health care needs, not just their own child.

Another protective process we observe in these families is an increased cohesiveness that develops among family members from working together to manage the extra responsibilities and from experiencing the sense of "knowing that we are in this together." They pay attention to

the strengths in each other, particularly the strength that develops in the siblings of the child with special needs. When people outside the family are unkind and insensitive, they often turn to each other for support and value those family relationships even more.

Another protective process in these families is their ability to achieve balance around multiple issues. One balance is between the child's special needs and their normative developmental needs. Another balance is between the child's needs and those of all family members. When one has extra demands, it is sometimes very challenging to figure out how to allocate limited resources of time, emotional energy, and money among competing needs.

Families learn how to balance the demands they face with new capabilities and find meaning in the circumstances with which they are faced. Somehow, they are able to see the situation as special and their child's condition as something that has helped them become the family they are. They come to value the uniqueness of their family. Many times they develop a completely new way of looking at life and they do not take as much for granted. They establish priorities and develop a deeper sense of values, often rooted in spiritual beliefs that may have existed before but were dormant. Sometimes they come to the beliefs in a new way.

What are the implications of these findings about risk and protective processes for service providers, policy makers, and researchers? First of all, it is important that we train providers to be respectful of families. Providers need to learn how to be family-centered in their care, and they need to be culturally competent in the delivery of services. Secondly, they need to function within service systems that support family-centered care. That has been a major barrier for many providers who are trained to deliver care for children with special needs. In the interest of cost-containment and time pressures, they often are not able to do what they are trained to do. Finally, we need to provide more kinds of psycho-educational programs that are well timed in terms of family need and that involve the whole family. Policy makers need to assure adequate funding for health, education, and social services for families of children with special health care needs.

We as a society choose to put significant amounts of money into medical technology research, which allows us to sustain the lives of many children who used to die at birth or much earlier in life. Hence, the prevalence of chronic conditions is greater. As a society, we need to commit similar monetary amounts to help sustain these families in caring for children with special health care needs. We also need policies that encourage the funders of services to merge the different funding streams. Often the programs are categorical, which creates a morass for families to navigate and often is very inefficient. Finally, we need to examine the impact of public policies on families' abilities to fulfill their functions.

There are many implications for research. As Jack Shonkoff mentioned in his keynote speech, there are always more questions than answers for researchers. We need to find better strategies for increasing family-to-family support, since it has been shown to be so valuable. We need to determine what factors contribute to family-centered service delivery systems. We also need to work on public attitudes about disability and chronic illness and impact them in a positive way. I am reminded of the words of a native Minnesotan, Hubert Humphrey, who said that a nation could be judged by how it treats its people in the dawn of life, children; in the twilight of life, the elderly; and in the shadows, those with disabilities. Let us remember that they are counting on us.

Tom Tonniges: I worked as a pediatrician in Hastings, Nebraska, for 18 years, and one of the first places I visited there before I started my practice was a Head Start program. I also visited every special education classroom in the school district and every service that was available for children. It was a unique opportunity, and, as a result, my early practice experience was grounded in working closely with early interventionists and the Head Start program. That influence has continued throughout my career.

I am going to talk about some of the major changes we are seeing in clinical settings and that

you are seeing in the children in your programs. Then, I am going to describe two programs that address some of the issues Joan Patterson talked about from a pediatric perspective. At the American Academy of Pediatrics, we aim to improve pediatricians' participation in and support of early education and early intervention programs. Certainly, we have seen a change in the children that we see in our practices. From the 1960s to the 1980s, we talked about learning disabilities and how we needed to be involved in care coordination. It is hard to believe we were educated in those topics; we did learn, though, the concept of care coordination, emotional disorders, functional distress, and educational needs of children.

However, from the 1980s onward, the children and families that we see are changing continually. Even though I practiced in Hastings, Nebraska, a rural community, I had three patients with pediatric AIDS. We also had children with other disabilities who were living longer. Certainly we have seen major changes in the last 20 years in cancer therapy for children and congenital heart disease. Children who never would have had a chance even 25 years ago are now surviving, and they have a high quality of life. Another issue that we have to deal with now in pediatrics is multiple gestations. These children are a significantly growing high-risk group due to the fact that many are born prematurely. They represent a specific challenge for us.

We are seeing a paradigm shift in health. It is a paradigm shift throughout our society. We are moving from a time of competing to figuring out how we can collaborate in health, from a disease-oriented health system to one that is health-oriented, from an assumed accountability to explicit accountability, and from a focus on institutions to a focus on community.

The American Academy of Pediatrics supports pediatricians and other health providers in performing community health activities. We are moving from a health model that is paternalistic and tells one what to do to one that encourages, empowers, and builds on people's strengths rather than their weaknesses. Why is it important for all of us to focus on children with special health care needs? These children, particularly those within the early intervention community, are at an unbelievably higher risk for almost all child health problems. In this population, child abuse and neglect is nine times higher, growth retardation is two and a half times higher, infant mortality is up to one and a half times higher, and fatal injuries are two to three times higher.

We cannot continue to approach families and children like the blindfolded men touching an elephant, where we all touch and feel part of it but do not see how it all fits together. For example, I had a patient who was the first of twins. His twin died at birth, and he went to a tertiary center. After about 5 months, he came back to our hospital for another 6 months before we were able to transition him home. He had 18 different pieces of technology that we had to help his family manage. Because we have gone from a time when the family doctor took care of almost everything to a highly technological age where we think that medicine can cure all, we have gotten away from the concept that families need to have a primary health care provider to help them manage and negotiate the system.

Out of these changes came the Medical Home Program for Children with Special Health Care Needs (MHPCSN). The concept is one in which the child and family are in the middle of a health care system with a provider or system to help them negotiate all the other services they need. This model is really an attitude. Health care needs to be accessible, and an effort needs to be made to meet the needs of all children. Certainly from a geographic standpoint, it has to be community-based. For example, we have a project in Nebraska where pediatricians fly into a remote area of Nebraska to provide care for about 300 children with special health care needs. This program significantly reduced the number of miles these families had to travel to get care.

Health care also needs to be financially accessible. With Title XXI, half of the 11 million children who currently do not have access to care are going to get health insurance of some kind. The care provided must be community-based with a multidisciplinary team as well as family-centered, as alluded to before. We as a profession have to understand that the child's primary source of strength and support is the family. We are beginning to educate our pediatricians about that fact. Parents are experts. I could describe all kinds of personal experiences in my

practice where a parent gave me a completely different perspective on what the problems were with that family. Families and professionals working together can dramatically improve child health. It has to be comprehensive, and primary health care has to be available 24 hours a day. Every child needs good primary health care. We have too many children that have to go to tertiary medical centers where they get fragmented care.

Pediatricians and other health providers have to know what resources are available in their community, and these resources must be continuous. The transitions of hospital to home, home to school, school to job or independent living, and primary to secondary to tertiary care need to be defined up front, particularly for children with special health care needs. Who is going to be responsible when the child goes to a medical center for his first 5 or 6 months of life? Who is going to make sure that the child leaves the hospital with his or her first two DPTs, oral polio vaccines, and hepatitis-B shot? That requires working together in a culturally competent manner.

Pediatrics is in transition. By the year 2000, more than half of pediatricians will be female, which I think is extremely positive. However, we need to work harder to get more minority physicians to pediatrics to pull this one off and do it well. It needs to be coordinated. We now help provide oversight to a set of grants from the Maternal and Child Health Bureau for this medical home concept. I am also excited about websites that provide information about children online. For example, if I see a child in my office and change his or her seizure medicine, I can input the information onto the child's website. The child care provider, the Head Start program, can immediately know that there has been a change in the child's medication and will know what to expect and look for. Technology provides real opportunity to improve children's health.

We have added to this a sense of shared responsibility because health care providers cannot be solely responsible for the "medical home." Parents also need to have responsibility for helping take care of their children, and everybody else has to have a seat at the table. However, we need to help families maximize quality by minimizing cost because cost certainly drives many of the issues and contributes to the fact that children with special needs do not always get what they need. The "medical home" helps establish a forum for problem solving. The result is a more efficient use of limited resources for children and families and an expansion in the expertise and competence of professionals.

We are completing a multidisciplinary training program in the medical home concept, which is a collaborative initiative of the Academy, the Maternal and Child Health Bureau, the Shriners Hospitals for Children, Family Voices, and the National Association of Children's Hospitals and Related Institutions (NACHRI). It is a unique training in that it includes pediatricians and other providers, such as physical and occupational therapists, as well as Head Start teachers and parents. We had our initial training a couple of months ago bringing together 20 families for an unbelievably moving, positive experience on how to take this medical home concept to a practical level and improve health care for families. The training program will eventually be available to the public, and we are promoting it through our own network of AAP chapters and in early intervention and Head Start programs.

The Healthy Child Care America Campaign addresses some of the problems facing child health care today. This program, funded by the Maternal and Child Health Bureau and the Child Care Bureau, is an attempt to ensure that children are placed in safe child care. We seek to train health professionals, starting with pediatricians but also training practitioners and other members of the early intervention field as well, in the 10 steps for ensuring healthy child care. We have a child care contact network comprised of more than 3,000 people and a wonderful newsletter that gives tips on how to ensure that a child care setting is safe and promotes the concept of the child care setting as an access point for health promotion and disease prevention.

This program will allow pediatricians to have different levels of involvement in child care settings. The first level would be to go to a child care setting to discuss health and safety issues or to be able to identify a quality child care program during a well child visit. The second level

would be involvement in a child care facility, such as advising on health and safety issues or serving on a local Head Start advisory board. The third level would be to serve as a health consultant with specialized training in the assessment of health and safety risks in child care programs. The fourth level of support would be as a consultant who would then train other people to do this.

I would now like to discuss some specific issues about children with special health care needs in a child care setting. It is very important for these children to have a "medical home" identified for them. One needs to know whom to call if a child has a seizure and how immediate resources can be accessed for that child. I am very happy to hear that Head Start is changing and that programs are encouraged to identify "medical homes" for children. These children need all the players identified as part of a multidisciplinary team working closely together. In my practice, I saw far too many cases where a child moved from an early intervention program to a Head Start program, but the therapist in one program never really communicated with the therapist in the other program. We must figure out a way to improve communication among the various players.

It is important for a member of the child care staff to serve as a child's health advocate. It is frustrating for providers to call and speak with somebody different each time, particularly if that person does not know or understand the child well. Health advocates must be encouraged to be informed about relevant issues related to the child care settings, such as possible allergens in the environment and the technology that a child might need.

There is an opportunity to develop a three-way partnership between parents, child care providers, and primary care clinicians. We find that when working with pediatricians, the element of their work that they like the most is when they can share their experience or when someone else shares with them an idea on how to improve the care provided. Child care providers themselves can help parents learn to identify the qualities that they should look for in a child care setting.

We have another program, the Community Access to Child Health (CATCH) program, that provides small grants of up to $10,000 so that pediatricians can collaborate and work with other individuals to improve access to care in the community. We have more than 12,000 pediatricians involved in the program now. We rely on the basic principle that local involvement increases professional satisfaction, and that local people using local resources are going to solve the local problems that large federal programs are not capable of solving. Some support from the Federal government is needed, but problem solving is going to happen at the community level because one improves child health care one child at a time.

If each one of us took responsibility for every child with whom we worked, we would see a difference in the children of America today. There is a pediatrician from California who started a CATCH program in Yuba City. He opened 11 elementary school-based clinics and serves over 3,000 students with approximately $2,000 a year per clinic by working with the local Rotary Club and a nurse practitioner. Literally, this pediatrician and nurse practitioner provide primary health care for 3,000 generally migrant minority children in that area. Coming together is a beginning, keeping together is progress, but working together is success. That is why we are here today.

George Isham: I am here because I have worked over the years with people who care deeply about children's health care needs. They have taken the time to educate me about children's health issues and have transferred their commitment to me, even though I do not work directly with children and have not been trained to work with children.

I want to talk about some of the system organizational issues that I see as the chief medical officer for Health Partners, a large health care system in Minneapolis, Minnesota. First of all, I want to discuss trends and address the growth of managed care. In Minnesota, managed care comprises 85% of health care in terms of people being enrolled in one form of managed care or another. One in four people in the Twin Cities has some form of health insurance from our

organization. It is a fairly high market penetration, if you will, with about 25% of the Twin Cities metropolitan area of 2.4 million insured in one way or another by our organization. We are the third-largest health care company in Minnesota.

As you know, 25% of Medicaid enrollment is through managed care. The federal government has decided that it seriously wants to control costs and is making an effort to shift enrollment of people in the Medicaid program as well as in the Medicare program into prepaid health care. The rationale for making this shift is very clear in budget discussions and in terms of reimbursement policies—we are paying less for these populations to receive health care. Again, one does not hear that talked about frequently. What one hears out of Washington is patient and consumer rights. One does not hear the very strong determination in terms of program development to cut costs.

About 26% of our enrollees are younger than 15 years of age. Twenty-six percent of 800,000 is a large number. This is the group we should be concerned about. Five percent of that population is children with special health care needs who account for more than 60% of child health expenditures. Here are the fundamentals of health insurance at work. A small amount of money is collected from everyone and is then paid out for those who really need it. In other words, a small percentage of the total population consumes the majority of health care resources. In 1992, the aggregate costs for children with special health care needs were $6.5 billion.

We received a Robert Wood Johnson partnership-planning grant for the purpose of identifying issues related to children with special health care needs and then designing proposals for a full grant. It is a joint partnership between the University of Minnesota, the Center for Children with Chronic Illness and Disability, our organization, and the Pacer Center, a community organization. The planning grant consisted of in-depth interviews of 35 parents of children with special needs and a financial analysis of 410 children with eight different conditions who were identified from our enrollment. We also conducted a survey of physicians caring for these children to determine what the issues were. Then we convened two community working groups, one of parents and a broader group of community health care workers that work with the children in various roles. The idea, of course, is to make sure we have a mechanism to build collaboration. We need to have planning groups that bring people together from the different disciplines to talk about how to bridge the gaps and put together programs.

Some of the fears identified in this process were that there is ambivalence about enrolling people with chronic illness and uncertainty about whether they are desirable or undesirable in terms of the insurance mechanism. There was also concern that there may be financial incentives to underserve children with significant health needs once they are enrolled because of the current flat payment mechanisms. There was concern that incentives to use in-plan providers may limit people's choices of specialists outside the system, and parents of children with special health needs are concerned that primary care physicians may not have the expertise needed to deal with some of these complex issues. They also feared that access to special equipment and therapies may be limited by the benefit set, and that enrollment policies and practices may be intimidating, confusing, and hard to understand. Copayments and deductibles may be seen as a barrier to care. Models of acute care may not apply here. In other words, the rehabilitative issues of returning people to functioning status obviously do not apply to individuals that were never functioning in the first place because of a significant illness. This is an issue that needs to be thought through in a much more significant way in the future.

Medicaid moving to managed care is another fear. What will that mean in terms of the federal government's commitment to program funding in the future? People can see what is happening, and those with children who have substantial medical needs that will continue indefinitely are particularly afraid that there is a lack of commitment for the future within both state and federal governments.

Now I am going to represent three points of view: parents, the doctors, and the community. We were delighted to learn that the relationship with pediatricians is very satisfying as far as the

children and the parents are concerned. About 80% are highly satisfied with the care they receive. The referral process, however, is cumbersome and awkward, and gets in the way. Claims processing is slow and inefficient. The claims come from multiple directions and from multiple organizations. Some people do not understand that the paperwork is just a notice and not a bill. Case management services are lacking and behavioral health services for the child are needed.

To underscore the point that was made earlier, stress was identified as a major issue in this group. Eighty-six percent of the population of families identified it as a significant issue, but only two of the families actually took advantage of professional resources. There is a big gap between identified need and resources being applied to the problem. From the parents' point of view, the information about in-plan resources, policies, and benefits is difficult to obtain. It is particularly frustrating for me as a medical director to know that we have the programs and people who care, but it is difficult to link them up with the people who need them.

Then again, parents are concerned about the future of health care coverage. This is not a concern about government, but rather a concern about private insurance. Will we continue to insure these people in the future? Will the private insurance market be there for children with special health needs? This concern mirrors the deep-seated concern that people have about state and federal funding in the future.

When asked, "Does your child's condition affect your ability to be employed?" 28% said yes. Obviously, parents are concerned that having a high-risk child will limit their ability to move from one employer to another. I should have said from the beginning that the population we spoke with has health insurance via the employer, so it is not the general population. Half of these families also receive additional benefits from state and federal programs, however, cobbling together funding from the private and public sectors in order to meet their total needs. We cover most direct expenses. However, families paid $10-$42 out-of-pocket per month.

The third major source of funding contribution to care is the family's private resources. The last is the educational sector. The school system often provides rehabilitative services, which often creates conflict between the medical and educational systems. From the perspective of the educational system, the school is meeting its responsibility to help children develop. From the medical system's point of view, however, the school system is trying to provide services that already exist. The barrier between those two perspectives is high. The policy issues related to whether we are going to fund these services out of the educational system or the medical system has entrenched defenders on both sides and the families are in the middle of that battle.

With respect to paying for care, it is startling that the annual cost for the 410 children is $6.2 million per year, of which $4.15 million is hospital costs. The average cost of $15,000 per child compares to an average annual premium in the Twin Cities, a place that is known for low health care costs, of just over $3,000 per family. This is how people benefit from the insurance principle. We collect a small premium from thousands of people to meet the special health care needs of these children. The hospital costs for the 25 most expensive cases range from $15,000 to more than $750,000. Hospital expenses take up the lion's share of these costs, out-of-plan specialists the second largest part, followed by durable medical equipment and office visits.

Now for the pediatrician's point of view. These are practices with patient panels ranging from 1,500 to 2,000 patients, of which about 20 have special health care needs. There are few special health care patients in these practices, but 6-20% of a physician's time is devoted to the care of these children. If a doctor has a complex case, he or she spends a lot of time on it and then sees a lot of colds, sore throats, earaches, and so forth in between. Most enjoy caring for special needs children. Notice that I did not say all. There are some that do not, and that is important to recognize. They are informed and able to coordinate care, and they want to coordinate care and are confident they can. However, coordination is difficult. Finding the agencies to provide what a family needs is difficult. If only 20 out of 1500 of a pediatrician's cases are special needs cases, a doctor can forget the details, such as who pays for all the required supplies and services. It can be very confusing and thus difficult to find the needed services at times. It is also difficult to find the time because there is a lot of pressure to see many patients.

Communities, meanwhile, see case management as focused on the cost and use of services for a specific agency. This surprised me. Each agency is looking out for its own set of philosophies and belief systems as well as its own budget, including our agency, in a sense. One of the advantages of collaboration is that it has the potential to focus on the total needs—a case management system that does not focus on the needs of the family, but rather a case manager of the case managers. We need to find a way to simplify that concept without losing the advantage of that expertise in terms of helping families cope.

Inadequate coordination between systems is rampant with poor community linkages. I spoke earlier about uncertainty and agency anxiety. The agencies' anxieties stem from 1994 when everybody thought that the health care reform effort was going to put all the community agencies out of business. Today there is anxiety because of the budgetary pressures that exist for different agencies. Families worry about the changing eligibility and future coverage of many necessary services.

In conclusion, the focus needs to be on the children and their families, not on the agencies. Coordination is required across medical, social service, and educational communities, and we need some innovative, fresh thinking. I remember one quote, in particular, that perspective is worth 100 IQ points. If we brought the right kinds of people together, we ought to be able to get smart enough to solve some of these problems of coordination across the different agencies.

Funding is fragmented and responsibility is debated. Until those issues are settled, we will have problems catching these families. It is a larger social policy issue. We at Health Partners or, in fact, we in Minnesota are not going to solve the issue. Some fundamental questions about the fragmentation of funding for the needs of these families exist. Payment incentives are a problem at both ends of the spectrum. In regard to capitation, there is concern that both insurers and doctors will try to avoid the expensive cases, a worry that needs to be addressed. On the other end of the spectrum, there is fee-for-service, in which case providers have an incentive to provide services that may not be well documented scientifically because they receive compensation on the basis of how many services are provided. Here is another opportunity for innovation, in terms of finding out how to get the right incentives for results in this population.

Lastly, I am not an expert on family stress, but I recognize that it is a substantial problem with a majority of this population. However, the gap between identifying it and doing something about it is both large and real. It is obviously an area where we need some work. What can we do? We can advocate for industry-wide acceptance of benefits based on the needs of children. In Minnesota, we have proposed a habilitative benefit for children, rather than a rehabilitative benefit. Frankly, I have been disappointed by the narrow-minded response from the Department of Health. We could have a broader and better discussion about how to accomplish that within the industry.

We should also expand case management and care coordination. At Health Partners, we have an opportunity to take a look at the case management programs and develop linkages with other case managers. This study will give us the impetus to start conversations on these topics. The redesign effort to increase coordination of care is already under way internally. Within Health Partners, our pediatricians are leading the charge. We must provide a special orientation for families with special needs and we ought to provide families with training so they do not have to rely on trial and error. We must also promote the use of mental health resources to close the gap on the family stress side. Perhaps we can make our hours of service more convenient to relieve at least one of the stress factors for these families.

Nancy Sheppard: As a worker in a Head Start program, I realize the difficulties of working with children with special health issues. We are thankful that the number of children with special health needs is small in relationship to the number of children. We have dealt with almost no children with severe forms of health impairment. Although we have had children with cerebral palsy and Down Syndrome, the majority of the disabilities we find are speech and language disabilities.

However, I believe we will be getting more children with special health needs, particularly as we start our Early Start program, and we will try to partner to provide care for some of these children. At times, I am amazed that a child can actually reach the age of 2½ to 3 and not be identified as a child with a special need of some sort. We have a 3-year old child that will be coming into our program next year who does not eat solid food. We ask ourselves how in the world could this have happened? He fell through more than a crack. He fell into an abyss. He was a premature child and was on a ventilator, and he never received any additional care. His family has undergone tremendous stress and has many other issues with which to deal. Their stress is heightened because the systems break down. They had Medicaid, but, due to a problem in getting the appropriate paperwork in to the appropriate people, they lost it. For a period of time, they went without care. It took 4 months to get the family on Medicaid again.

Why does it take 4 months to get a family back on Medicaid when nothing has changed? If a family has been on Medicaid and something happens to break that chain, such as an increase in income that makes them no longer eligible for care, and when they join Medicaid again in the future, they will have different sources of care. Children come through our programs with physicals over a period of years signed by three or four different physicians' offices.

It is obvious they are not getting consistent care. How do you reconcile that? Somebody has to help the parents become advocates. We work with a population in which 80–90% speaks English as a second language. Not only do they face the difficulty of maneuvering the system that all families face, but they also have to do it in a foreign language. Accommodations are not always made. Head Start has done a good job of advocating for these families by recognizing that they are not getting what they need and helping the parent learn how to be an advocate, not just within the health care system but also within the school system.

Some of our most difficult collaborations involve children who are dually placed. We have special needs children who go to special education preschool for occupational therapy and then come to us for the other part of the day. Just getting the transportation set up so that the bus will pick them up and drop them off at the right time is very difficult. All of these issues have to be worked through and families need help understanding how to go about doing that because, unfortunately, when the children turn 5 years old and go to kindergarten, we cannot do that for them any more.

It is a challenge we all must live up to. We can improve the situation by making partnerships with organizations and getting to know the health care providers in our area. It is helpful if providers recognize that Head Start is a significant player in these families' lives and that it can be a partner and help make their job easier and more effective. I hear from many providers that families do not keep their appointments. I do not know if that is true, but it is important for us to know that so we can help them keep their appointments. We can do that more effectively than a provider with a large practice.

As a worker in a Head Start program, I see challenges ahead. We will see more and more children come into our programs with much more complex health issues. We need to live up to those challenges.

AUDIENCE COMMENTS AND QUESTIONS

Question: I have a question regarding the medical home concept. Head Start is wonderful for the pediatrics community. Under Medicaid, one used to be able to get some kinds of pediatric services at a Head Start program. With a medical home, sometimes the large agencies and organizations are not familiar with the communities in which the families live. I am caught between what the Head Start standards say, what the pediatric community says, and where our system is going. When talking about reducing stress, I believe that was accomplished when one knew that a pediatrician, speech therapist, or other health worker would be at a Head Start

community organization every week. Medical homes, on the other hand, are big corporations that do not bring the services to the child.

John Pascoe: Your concern is that if the medical home means providing services at a certain place away from Head Start, it may actually erode the positive flexibility of providers going to Head Start sites to provide services. That would no longer be possible if all services must be provided "within the medical home," which might be five miles away from the Head Start site. The medical home would be yet another source of stress for the family.

Tom Tonniges: That is where local community problem solving is important. From the other perspective, physicians have gone to the site to do physicals, and then the Head Start program decided they were going to contract with another provider so that they could be paid for doing the physicals. This interfered with the medical home. The real issue is to educate families on the need for a medical home. A Head Start program could work with providers and say, "It is impossible for us to get these 30 children in. Can the pediatricians come out?" That is still a medical home if one convinces the family that they are being seen at Head Start for convenience, but they are seeing the same provider. The site is not necessarily important, but the attitude and the philosophy of continuity are very important. In some communities, it may make sense to ask the medical homes to come to the site. In others, it may not.

Mireille Kanda: We are all on the same wavelength in terms of looking at the ultimate goal for families. When looking at the medical home, in various constituencies it is not necessarily going to be the same for every child. For example, Head Start serves migrant families. Because of the very nature of their lives, it is a big challenge to serve them.

We are now in the process of thinking how the medical home can provide continuity of care. Head Start is in a time of transition. For more than 30 years, Head Start programs did developmental and hearing and vision screenings very well, but now they have relinquished this duty. Often it is easier to do something ourselves because we know when we have done it, it is done. However, sometimes the ultimate purpose is not best served in this way. In a sense, we are looking at the fact that there is life beyond Head Start. We see the mission of Head Start as a mission of empowerment. Not only do we want to be sure that families get what is due to them, but we also want to see that they are self-advocates beyond Head Start. It is a challenge. However, it is a journey, and we are moving along that continuum.

I am so glad that we are having this conversation also with our colleagues in managed care because sometimes it appears that managed care is not going in the same direction as we are. That is why we are encouraging programs to have managed care officials and managed care providers as members of the health services advisory committees. We are seeing great examples of collaborations that we did not expect to see.

Comment: If a medical home is established, and then the child transitions from Head Start to the K-12 world, the purposes of the medical home will be defeated if we do not start collaborating with the education community.

Pascoe: Are there similar efforts or collaborations for children entering school? Are there efforts by the Department of Education related to the medical home concept?

Tonniges: At the Academy, we are working very closely and cooperatively with the Maternal and Child Health Bureau through their Title V program, Children's Special Health Care Needs, and Interagency Planning. At the federal level, this discussion is brought up at every meeting. We also work with our state chapters to take the message to the state-level interagency planning councils. People who work with the special population and children at risk are talking about the

need for this coordinated, comprehensive, community-based, family-centered, culturally competent, accessible, and shared responsibility concept. We have made progress over the last couple of years.

Pascoe. If one is a provider out in the field and a claim is denied within a managed care context, what is a realistic expectation for an appeal process?

George Isham: In terms of appeals, the mechanisms for appeals are state-dependent. Minnesota has state legislation that requires certain notifications to members about their opportunities, rights, and abilities to appeal when a claim is denied. Secondly, there are a number of protective mechanisms in terms of levels of appeal that are available to members. In our case, there are at least two levels of medical review with specialists in the field. The last review is by the community board of directors, which has the final opinion. There is also a state-mandated process where the Department of Health can review claims at any point in the process, and there are the civil systems for legal action. The appeal mechanisms are very strong. In fact, what is being proposed in the patient bill of rights already exists in Minnesota in our health plan.

In regard to some of the federal programs, one has to deny coverage to an individual in order for them to qualify for other programs. The needs are so great that more than half of these people are getting support from those federal programs. I do not know how to solve this problem in Health Partners because I do not have control of the whole system. However, what I can control is the design of the benefit package and responding to complaints. When there are many complaints, I either look at the authorization mechanisms and try to simplify and streamline them or create direct relationships with the specialists providers if that is the source of contention.

All of what is known in science is not necessarily covered in the benefit set. Likewise, all that is covered in the benefit set is not necessarily validated by science. To take a more proactive approach to the problem, while we want to make sure that people have the right to appeal and can exercise that right if they have a disagreement, our objective is to eliminate the complaints by providing the right service at the right time.

Pascoe: With the recent immigration of families into the community from foreign lands, there are implications for caring for children with special health care needs from families that are ethnic minorities. Is it valid to conceptualize cultural adjustment as another major stress as these families are trying to adapt while taking care of a child with a special health care need? Are there concerns other than providing culturally competent care?

Joan Patterson: By and large, families experience a certain amount of stress and strain when they have a child with special health care needs, regardless of whether they are immigrants or from a minority group. How they manage that varies, and there are strengths in the diversity. We tried to replicate our longitudinal study in Chicago with an African American population. When we enrolled the participants into the study, we had someone in the clinic to talk to the parents when they brought their child in for a medical visit. Interestingly, more than half of the children were brought into the medical clinic by someone other than a parent. That was not what we expected, and it naturally raised a set of questions about the mix of caregivers for these children. This is a reflection of the diversity of caregivers for these children. Thus, when we think about the family and family caregivers, we need to be inclusive of these other caregivers.

To the extent that immigrant or minority families have faced stress, in many instances they have already developed certain competencies or capabilities for dealing with added stress and they can bring those strengths to caring for a child with a special need. However, when these are low-income families, ongoing issues of poverty and providing for the basic needs of the family

confound the effect of resiliency, and sometimes it is hard to give high priority to a child with special needs.

For example, in a study of Native American, inner-city families in Minneapolis who have children with asthma, the child with special health needs is just one of many issues these families are addressing. Often they are not able to provide prophylactic care for their child with asthma, and they often end up using emergency room services. Thus, the programs developed for them require a much more holistic, comprehensive approach than educating them about asthma management. Generally, this is a major problem with regard to asthma. Its increasing prevalence in the inner city is due to a whole host of environmental factors, and care and treatment for these children need to be addressed.

Regarding immigrant families, often there is a different belief system that is culturally grounded and must be taken into consideration in the organization and delivery of services. We have come to recognize the importance of integrating the different belief systems in a way that works for the families. For example, Native American beliefs dictate using traditional healers along with Western-trained medical providers. This needs to be respected in order to maintain the integrity and identity of the family and to provide an optimum environment for the child with special health needs.

Kanda: I would like to mention the collaboration that the Head Start Bureau has entered into with the Hilton Foundation to promote training within Head Start programs and communities for taking care of infants and toddlers with significant health care needs. It is a promising initiative that will continue for 5 years and will involve several activities. We are hopeful that it will expand the scope of what Head Start can do to address the needs of infants and toddlers with serious disabilities.

Systematically Building Multiple Protective Factors to Increase Head Start Children's Mental Health: The Evaluated and Replicated Multifamily FAST Program

CHAIR: Lynn McDonald
DISCUSSANT: Donna Bryant
PRESENTERS: Lynn McDonald, Thomas Sayger, Estella Payton, Horace Whitfield

There are three steps of the collaborative, parent-professional FAST (Families and Schools Together) program for improving the mental health of children of Head Start families: outreach visits, multifamily activity sessions, and ongoing monthly parent-run meetings for 2 years, including through the transition to elementary school.

Outreach to whole families involves inviting them to participate in the multifamily sessions that are held by peer parents or classroom teachers during evenings or weekend hours at the convenience of the parents. The meetings take place in the homes of the peer parents or at agreed upon local locations.

Multifamily sessions include 12–15 whole families for 2½ hours of structured, interactive personal activities and are repeated each week for 10 weeks. The activities are based on family therapy theory developed by Alexander; Minuchin, Patterson, Satir, and Whitaker, the family stress theories of Hill and McCubbin, and research studies on the child mental health and community development strategies of McDonald.

FAST activities systematically build protective factors for children and parents. Activities include: (a) a FAST welcome and creation of a family flag directed by the parent; (b) a meal where the parent delegates a child to serve their family; (c) a family drawing and talking game where the parent ensures each family member has a turn and inquires positively about others; (d) a "feeling charades" games with the parent directing family members to "act out" or guess from selected feeling cards; (e) peer activities such as buddy time followed by a parent self-help group which builds an informal social support network in age-appropriate groupings; (f) parent-child "special" play time where the parent is nondirective and nonjudgmental, following the child's lead for 15 uninterrupted minutes with active support from the FAST team; (g) a fixed lottery and meal preparation with each family highlighted as a Big Winner, then responsible for cooking the meal the next week, thus encouraging reciprocal and respectful support; and lastly, (g) a closing circle and final ritual to build traditions across families and community members.

The FAST team parent-professional provides support and coaching to the low-income, stressed, and isolated Head Start parents as they take the opportunity to engage in these family activities. To help the parents be successful, they behaviorally rehearse: requests of compliance from their Head Start child in gradually more complex behaviors without using coercion; organizing family communication through systematic turn-taking with positive inquiry; repeated observation, identification, expression, and labeling practices of eight basic emotions among family members; appropriate use and delegation of parental power; playing responsively with the Head Start child to create a "goodness of fit;" and, supporting the child's delayed gratification.

Relationships are enhanced between family members and friendships are built across the involved families over the 10 weeks these routines within a multifamily context are repeated. These family bonds and community relationships are protective factors that reduce the impact of stressors on the child's development and enhance the child's mental health and resilience. Four-year follow-up data on FAST parents indicate parental functioning is also increased.

Data from a 5-year Center for Substance Abuse Prevention program development/evaluation grant were collected on FAST children in seven Head Start centers in Dane County, Wisconsin. Pre-, post- and 6-month follow-up evaluations of 30 children's behaviors, (using Patterson's

checklist), and mental health screenings, (Achenbach's CBC), showed statistically significant improvements at home and at Head Start that were maintained 6 months later. In addition, measures of family functioning (Moos and FACES III), and family isolation (Abidin Sub Scale), showed improvements also maintained overtime (McDonald and Sayger, 1998).

FAST Head Start has been replicated in four Head Start centers in Baltimore, Maryland, using a preschool FAST Program Workbook (McDonald, 1997), the FAST Outcome Evaluation Package (McDonald and Billingham, 1990; 1998), the FAST Process Evaluation Forms (McDonald, 1992; 1998), and three site visits by a Certified FAST Trainer. Six Head Start parents in Baltimore were interviewed in a public meeting to gain the consumer perspective on the program replication; they were enthusiastic and recommended all Head Start families are invited to FAST.

References

Billingham, S. (1993) Evaluation Research Design for Families and Schools Together Program (FAST). Dissertation, Psychology. DePaul University, Chicago.

McDonald, L. (1990; revised: 1992, 1998). FAST Program Workbook. FAST International: Madison, WI.

McDonald, L. (1992; revised: 1998). FAST Team Trainer Manual. FAST International: Madison, WI.

McDonald, L., Billingham, S., Conrad, T., Morgan, A., & Payton, E. (1997). Integrating strategies from mental health and community development. *Families in Society,* (March/April), 140–155.

McDonald, L., Coe Bradish, D., Billingham, S., Dibble, N., & Rice, C. (1991). Families and schools together: An innovative substance abuse prevention program. *Social Work in Education,* 13(2), 118–130.

McDonald, L., & Payton, E. (1998) Parent involvement in program evaluation and research. *Family Resource Coalition of America Report.* 16(4), 20–21.

McDonald, L., & Sayger, T. (1998) Impact of a family and school based prevention program on protective factors for high-risk youth. *Drugs and Society.* 12(1/2), 61–86.

Sayger, T. V. (1996). Creating resilient children and empowering families using a multi-family group process. *Journal for Specialists in Group Work,* (21), 81–89.

Addressing Difficult Issues of Mental Health Research and Practice in Early Intervention Programs

CHAIRS: Mary Bruce Webb, Faith Lamb-Parker
DISCUSSANT: Brenda Jones Harden
PRESENTERS: Philip Leaf, David Olds, Gloria Johnson-Powell

■ Mental Health Is Not a Four-Letter Word

Philip Leaf

The focus of this paper is a multifaceted program for delivering mental health services to children and families in Baltimore City, highlighting Head Start. We are currently funded by the Administration on Children, Youth and Families (ACYF), the National Institute of Mental Health (NIMH), and the Center for Mental Health Services. The Department of Education and the Office of Juvenile Justice Delinquency Prevention (OJJDP) have funded us in the past. There are many agencies, both community-based and nonprofit, and funders of these services who are very interested in Head Start children and families.

When one is concerned about mental health services and service delivery, mental health and substance abuse go together. If when thinking about mental health, one only thinks about NIMH, or if when thinking about substance abuse, one only thinks about the National Institute of Drug Abuse, then one is missing an enormous body of literature, including best practices that are being developed.

I like to use OJJDP as an example. They have a wonderful manual where they describe best practices, but they also do something that very few, maybe no other, federal agencies do: They also show what does not work by describing those projects they funded that did not work the way they thought they would. One of the things in understanding research is understanding both what works in what kinds of situations and what is needed to make things happen.

In Baltimore Head Start programs, almost all of our children are African American, but there is enormous variation in terms of household composition, such as marital status, where individuals are living, if they are working, and so forth.

One of the real challenges for Head Start programs is parent and family involvement. Many Head Start families have one or both parents in the household working or in transition to work. If you have models where you are developing parenting services, parents are no longer easily available during the day, so one of the issues is how to deliver services to them.

The other issue is that there are many Head Start partners who also are serving Head Start families and parents under very different circumstances. We heard earlier from Carleatha Johnson about some of the difficulties of dealing with schools because of their different perspective.

We have some important opportunities. Transition-to-work programs are very interested in Head Start families. Equally important, these transition-to-work programs are putting enormous stress on Head Start families. The children see that their parents have to change their entire schedules, and parents experience the pressure of potentially losing their benefits. Many of these problems become manifested as behavioral problems, both in the children that one sees in these settings and in difficulties within the family. Clearly, within a Head Start center, there might be very specific behavioral management problems.

There are also developmental issues such as language skills and the inability to learn how to read. A good Head Start program will wind up preventing many behavioral problems because the children feel comfortable with what they are doing. It is age-appropriate. The families feel comfortable. Therefore, often the best prevention program for mental health is having good,

appropriate services that are targeted developmentally. However, there are going to be children who are manifesting problems. Within the Head Start centers, we are trying to increase the capacity of all staff to understand child development behavioral problems. We do not always pay enough attention to staff training. We assume that everybody is familiar with early childhood development. There are staff in the building who are not necessarily oriented toward early childhood development. There are also wide ranges of competencies and experience among even the professional staff.

When we do training, we include the secretaries and the custodial staff. Everybody is involved because we find that parents talk to all of these people. If one does not have a coherent program, if everybody does not understand why it is important for the parent to come to the parenting program in the evening, that becomes a problem. Parents are as likely to talk to somebody as they are walking out the door as they are to talk to a family service coordinator.

This is what I like about Head Start. It is a whole family trying to work together with other families. What has become increasingly important, however, is that many Head Start families have relationships with social services and agencies. One is certainly the schools, because many of them have older children. The problems in these other agencies, to the extent that they affect the family, also then affect the children being served.

One of the concerns around this issue of multiagency intervention—and this is the new intervention spectrum that the NIMH has developed as part of their new prevention initiative—is recognizing that we need to have a continuum of universal services as well as selected services. Head Start is a "selected services program" since most of the children are at risk because their families live in poverty. There are going to be more indicated services, whether they are mental health or other services, for children who are not doing well, whether it is a developmental or mental health issue.

I mentioned the issue of comorbidity. Many children have both language and behavioral issues. In younger children, many deficiencies may ultimately be manifested as behavioral problems. The strategy to resolve those problems is not necessarily a mental health service. One needs to understand what is going on in the families and what is going on in the program that might be promoting the problems. In terms of the programs, when we talk about mental health issues, we have crisis management, parent/family involvement, and comprehensive plans at the classroom level.

It is important to monitor how well these systems are actually working as well as recognize that when there is staff turnover, although there may have been a great training last year, there are new staff who are not necessarily "onboard." In Baltimore, we have a lot of staff turnover. We have people who are moving on to better jobs, and we have people who shift jobs because they are moving out of the neighborhood or out of the community. Increasingly, we have former parents being hired by the Head Start centers.

We have spent too little attention on how to develop the capacity of centers to effectively train people. In Baltimore, because we have multiple centers and they are relatively small, we must pool resources.

Likewise, when there are issues, we use peer and staff mediation and social skills instruction. We focus on how to have a curriculum that is appropriate, and we must revisit these issues each year because we find that there are enormous changes from year to year in the characteristics of the children.

Increasingly, there is an interface with the medical side. We train our staff to provide consultation to families on new medical arrangements. Maryland has gone to managed care. We thought that if we brought people in from managed care programs and health care providers, they could talk about access and how to negotiate these systems. We forgot that many of the people that work in Head Start programs are not making a lot of money. Some of them are actually eligible for Medicaid themselves, even though they are working. So we spend a lot of time with our staff, training them on how to negotiate the problems for themselves, not just for the people they serve.

The same thing is true with social services and juvenile justice. There are a lot of complicated internal changes going on. Staff need to understand that these systems are changing enormously, that each of these systems has a problem with managed care, with changing state regulations, and with the new federal regulations.

Therefore, in Baltimore, we have developed multiagency training where we get people together and have them cross-train each other. We let them know what the new developments in their fields are to try to speed up this knowledge development because we find even some of the case workers are not that knowledgeable about other parts of their own program.

Social service programs are enormously diverse, and it is difficult to keep up to speed. Head Start families are involved with many different community agencies. Many communities, not just Baltimore, are moving toward developing service systems where the child and the family are at the core. Maryland has state legislation where each of the jurisdictions has to have something called a Local Management Board where any of the agencies that provide child and family services, and all of the large ones, including public agencies, are members. Consumers are also included on these boards. In Baltimore, the Mayor appoints the board members. Carleatha Johnson and I are on the board, and I coordinate a work group that is called the System Development Coordination Work Group. One of the advantages of linking up with researchers, in terms of identifying best practices and then getting them involved in the actual delivery, is that one is able to both tie into new innovative practices through research and make sure the research is relevant to the kinds of problems that are being faced. Certainly my research agenda, the kind of things that my colleagues and I are looking at, has changed enormously because of these ongoing contacts with different agencies and providers.

Often when thinking about mental health services, one thinks about somebody giving psychotherapy in an office. However, there is a whole continuum of mental health services, and many Head Start families are going to be tapping into these services at various points. It is important to think about preventive efforts and early identification. Many communities are trying to initiate these programs earlier. The reason I got involved in Head Start is that we were starting school-based programs, and the school officials were saying that the children were coming in with problems. We started talking to staff at Head Start centers who told us that they had children with serious behavioral and emotional problems.

Although when we started, we said mental health services for 3- and 4-year-old children is not what we wanted to be doing, it became clear that if we did not start the services, collaborating with Head Start programs in developing a citywide agenda, we were going to continue to find, as we did with some of our surveys, that families were often trying for 5 or 6 years to get services for their children. That puts enormous pressure on families over time. The children also finally get bad enough that they "deserve" a service; that is, they have a suicide attempt or they become very violent. Yet, we have known these children for a long time. Thus, many of our communities are trying to develop better service systems for these children at an earlier stage.

Head Start programs need to be players in advocating to make sure that these different systems are looking at their constituencies and that they are using programs that have been demonstrated to be effective with targeted children and families. As people who understand the needs of children and families, you can be important collaborators in this process.

Likewise, there is foster care. One of the issues around therapeutic foster care is getting programs that work. Increasingly, social service agencies are providing mental health services. Now, with the consolidation of Medicaid in many states, instead of having freestanding programs, they are often using Medicaid funds to pay for these services. What we find is that all of the agencies—social services, educational services, health services, juvenile justice, and substance abuse treatment—are now getting their funds out of the same "pot." That means that as people working in Head Start who understand the needs of families, you can often be important intermediaries in creating a service system in your own communities that addresses these issues.

Regarding vocational rehabilitation and transition to work, one of the things that we are

negotiating in Baltimore is the use of Head Start centers as work training sites. There have always been GED programs and some work programs, but there also has to be child care and other services that are important to provide to families. There are family service coordinators who can often facilitate and continue working with a family to make sure that they are able to obtain good jobs and then maintain those jobs. They help parents who have problems with their children who may be reacting to the changes that are going on in the families.

The Department of Social Services is interested in being able to improve their outcomes. Having parents placed in jobs that they are then able to keep, by working with agencies such as Head Start that are traditionally already working with these families, is key. Departments of Social Services in most states now actually have funds to move people into the workplace, such as funds for child care. You have staff who have very good relationships with parents and an understanding of what their needs are. These are opportunities to coordinate service delivery for improved outcomes for families.

One of the things to remember is that there are many children in Head Start who are in need of treatment services for emotional and behavioral problems. Our data indicate that around 20% of the children need these services. If we use parents' ratings, our data indicate that 40% of parents identify their children as having problems.

One of the things that we wondered about was that if we put a clinician in a Head Start setting, would we find those services to be acceptable? We had Head Start centers hire the clinicians we provided, so this was a collaboration with our local Head Start centers. However, we asked would those clinicians be able to identify the children who had problems and provide the services? We found that by the second year of operation, we were picking up two thirds of the children who were manifesting the highest levels of problems. We thought that was very positive. We got comparable results, whether it was the parent baseline rating or the teacher baseline rating.

The question then is if we have clinicians in the centers, do the children get better? Do the children have fewer behavioral problems over time and is that related to seeing the clinicians? For children who did not have contact with clinicians in these Head Start centers, there was a slight increase in the percentage of those children who manifested behavioral problems in the spring. For those children who did have some clinical contacts, and this included a whole range of clinical contacts, 30% were manifesting problems at our baseline screening in the fall of the year. We were able to reduce that by one third.

We still have many children who are manifesting problems. One of the issues is that there is only so much that Head Start centers themselves can do. Now we have another round of interventions with a more sophisticated intensive parent training program combined with other services, so we are continuing to improve. Again, if one looks at another domain, anxiety for example, we had a 40% reduction of symptoms for children in clinical services and an increase in symptoms for children who did not receive clinical services.

The conclusion of a recent advisory group for the National Mental Health Council concerning their priorities for prevention research was that there needs to be an increase in their developmental perspective. That is consistent with what people in Head Start have always been saying. They need to understand the development of emotional and behavioral problems—the causal factors. They need to translate research into knowledge for application in community settings. I would argue that Head Start centers are a prime community setting for the translation of this research, and, as collaborators, you have potentially many opportunities.

There needs to be a range of approaches dealing with social systems and policy changes. Head Start is informed about what some of the barriers or stresses on families are that need intervention, besides just clinical services. How do communities need to reorganize themselves, particularly with a positive focus?

What we are going to be seeing over the next few years is much more of an interest in community-based interventions applying psychological principles. It is trying not to see people

as coming in to see a clinician in an office, however, but focusing on communities with all their diversity and trying to understand which practices work best with which kind of families and which kind of issues and how to implement them. How do we get our psychological research into the communities in a way that they are going to be effective over the long run with diverse families and communities?

As consumers of these interventions, you must provide feedback to keep researchers focusing on things that you consider important.

■ Home-Visiting Services: Are We Going to Use Evidence to Guide Policy and Practice?

David Olds

I am concerned that in this era we see a lot of pressure to rush to conduct randomized trials before interventions are adequately developed from the standpoint of their theoretical and clinical foundations. The result of this is that we find interventions that are tested and found to be ineffective, and now everyone is wringing their hands about what it means.

I would like to argue that we need to spend a lot more time at the front end. That means understanding clearly what it is that we want to produce with various types of preventive interventions. What do we know from the research standpoint about the likely causal factors that are leading to the kinds of outcomes that we are trying to effect? What do we know about good theory and clinical practice that is going to lead to the alteration of those factors that are contributing to the kinds of problems that we are all concerned about?

If we do not lay the groundwork for interventions in that kind of thinking—if we do not carefully examine what we are doing from a clinical standpoint and bring together research at that front end—then we will continue to have a string of failures.

I will describe a program of research that my colleagues and I have been conducting for the last 20 years and that we think has finally reached a stage of maturity that will allow us to start thinking seriously about how it might have implications for practice and policy.

We have not succumbed to what is all too often the approach that says, "Fire, Aim, Ready." We have tried to approach a set of problems with what we hope is going to be a way for the field to think about the relationship between science, practice, and policy.

The program we have been testing is a prenatal and infancy home visitation program for low-income families. The program has three broad goals: (a) to improve the outcomes of pregnancy, (b) to improve children's health and development, and (c) to improve parents' own life course development.

The particular problems that we are concerned about affecting include preterm delivery and low birth weight, which are the leading correlates of infant mortality and morbidity in western societies. We are concerned increasingly about the prevention of neurodevelopmental impairment. Preterm delivery and low birth weight can cause neurodevelopmental impairment. However, it can also be caused by other factors during pregnancy, such as exposure to toxins, such as tobacco, alcohol, and illegal drugs, and unattended pregnancy complications. Neurodevelopmental impairment is a leading putative mediator, a causal factor in the development of conduct disorder, and, later, crime and delinquency.

We have also been concerned about the prevention of child abuse and neglect, which according to the U.S. Advisory Board on Child Abuse and Neglect is a national emergency. We are also concerned about the prevention of childhood injuries. Injuries are the leading cause of death among children age 1 to 14. Furthermore, we are concerned about the prevention of successive, unintended pregnancies and reduced participation in the workforce because these

factors conspire to enmesh families in poverty and, thus, increase the likelihood of other problems.

More recently, we have been concerned about the prevention of school failure, conduct disorder, and crime and delinquency. When we began this work more than 20 years ago, I would not allow myself to even imagine that what we were doing during pregnancy, infancy, and the toddler period might affect later development. It seemed like it would have been far too overreaching to imagine that we could have those kinds of effects.

Many of you in this room may be thinking this man is out of his mind to think that a single intervention could have an effect on all these major societal ills. It is the height of hubris to think so. How could this occur?

This is where research and theory come together to guide intervention. If we are concerned about things like preterm delivery and neurodevelopmental impairment on the part of the child, research evidence shows that there are some major modifiable risks for those problems that we know about during pregnancy. They include cigarette smoking, alcohol consumption, use of illegal drugs, and unattended pregnancy complications, all of which theoretically might be affected by, in this case, a nurse home visitor who helps parents both learn about the consequences of their behavior and develop the capacity for behavioral change. The last piece, the capacity for behavioral change, is a piece that is often missing from many of our preventive interventions.

I also want you to pay attention to the way in which the components of the intervention fit together. Neurodevelopmental impairment is a major risk factor for early emotional and behavioral disregulation. Babies that are exposed to tobacco in utero and as newborns have much greater difficulty regulating their states in the first few days and weeks after delivery. They are at higher risk for later conduct disorder and behavioral ADHD-like symptoms. Those children are much more difficult for parents to care for.

The program is also designed to directly affect the care parents provide to their children. Beginning during pregnancy, we start helping parents adapt to the care of their child. Visit-by-visit protocols guide parents in their adaptation to the care of their children, considering developmentally normative challenges during the pregnancy and the first 2 years of the child's life, with a specific focus on helping them manage behavioral problems, such as crying. The protocols also help parents start thinking during pregnancy about their own child rearing histories, the kinds of care that they experienced from their own parents, what they may want to reproduce, and what they may want to change.

There is also an explicit focus on the maternal life course, preventing future pregnancies, and eventually becoming economically self-sufficient, so that parents are no longer dependent on welfare. If parents are integrated into mainstream societal institutions, they become less susceptible to substance abuse.

It is important to understand that this is a program that starts with low-income, pregnant women who are having their first babies. This is a transition for them. Many of the mothers with whom we work are teenagers. They do not have any other children to care for. They also have not become heavily involved in substances because they tend to be relatively young. So this is an opportunity, maybe an opportunity of a lifetime, to alter their life course trajectories and the care they provide to their children by addressing the enormous physiologic and social behavioral changes the parents themselves are going through at this stage in their own life course development. During the first 2 years of the child's life, nurses completed between 23 and 25 home visits, and during pregnancy they completed between 7 and 9 home visits.

To the extent that we have had an effect on reducing subsequent pregnancies, for example, it makes it easier for parents to care for their children. To the extent that we have helped women improve their economic self-sufficiency, over time, we think they are going to live in safer neighborhoods and their children are less likely to be exposed to negative peer influences, which is a major risk factor for children's development of conduct disorder.

I hope you see that there are ways in which this program, from an epidemiological standpoint, has been brought together conceptually, but also how it has been guided by three interrelated theories: human ecology, self-efficacy, and attachment. Those theories provide the clinical method "meat" to the intervention. It is not just a matter of going in and teaching about the adverse affects of these behaviors and conditions on certain aspects of development. It involves thinking very systemically and deeply about how we can bring about enduring change on the part of parents' behavior in family context.

We have been studying this program in a series of randomized trials for more than 20 years. The first study was conducted in Elmira, New York, with promising results. We wondered if we could reproduce these findings in a major urban area with a primarily African American sample. A second study was later conducted in Memphis.

More recently, we have been studying the relative efficacy of nurse home visitors versus trained lay community home health visitors. We have done that because there has been a rapid proliferation of paraprofessional home visiting programs in our society in the last 10 years or so without a lot of strong evidence that these programs work. We wanted to know why the paraprofessional programs studied to date had failed.

Was it because of the models with which the programs had been provided to work with families at this stage in their life cycle? Or was it something about the background of the home visitors themselves that somehow compromised their ability to work effectively with challenging families? We are now testing this in Denver by giving both sets of home visitors essentially the same program protocol and looking at the relative efficacy in working with families over time.

In the Elmira study, the sample was primarily White. This was what we might consider to be closer to the efficacy end of the continuum on the research scale. By efficacy we mean that this was a program that was conducted under relatively favorable conditions. The same set of nurses worked with the families for the entire 5-year period of the program. There was no staff turnover and a lot of enthusiasm. As a result, the effects we observed are likely to be upper-bound estimates of what we might be able to achieve with a program like this.

During pregnancy, we found that behaviors improved, with reductions in obstetric complications and hypertensive disorders in pregnancy. The reduction in hypertension was not statistically significant, but we hypothesized that we would see increased effects in Memphis. We also saw increased levels of informal and formal support for the family and reductions in the rates of preterm delivery and low birth weight among smokers and very young teens.

We did not hypothesize at the beginning of the Elmira study that we would see effects on birth weight, in terms of length of gestation, conditioned by women's smoking status and age. So we hypothesized explicitly that we would see that effect in Memphis, but we did not. In part, we did not because the rate of cigarette smoking among African Americans in Memphis was 7% as opposed to 55% in the Elmira study. We violated the principle that I outlined earlier. That is to say, one needs to understand the epidemiological foundations of risk for adverse outcomes, and that needs to be population specific.

We also saw in the first 2 years of the child's life that there was an 80% reduction in the rates of state-verified cases of child abuse among women who had all three of the risk characteristics used for sample recruitment; that is, they were poor, unmarried, and teen-aged. There was a corresponding reduction, more than 50%, in the rates of emergency room encounters in the second year of the child's life. That is, when children are mobile and getting into things, the rates of injuries, of course, can go way up.

The rates of child abuse and neglect are a function of women's sense of control measured at registration, that is, the extent to which women feel that they can manage their life circumstances and have an effect on a variety of aspects of their lives. We have estimated the rates of child abuse and neglect in the first 2 years of the child's life as a function of whether they were in the comparison group or whether they were nurse-visited.

For poor, unmarried teens, the 80% difference in the rates of child abuse and neglect was

concentrated among the poor, unmarried teens that had little sense of control over their life circumstances. We see the same pattern of results when we look at the number of emergency room visits in the second year of the child's life.

Those results emphasized for us the importance of focusing the intervention itself on promoting women's sense of self-efficacy in managing their lives' challenges. It allowed us to double-back and look at that theoretical aspect of the program and reinforce it in the Memphis study.

In Memphis, we hypothesized that we would see the same pattern of results, but that the effects would be conditioned not only by women's sense of control over their life circumstances, but also by other individual attributes, such as their mental health symptomatology and their intellectual functioning. We felt that there would be indications of personal coping capacity that would condition the effects of the program. Women with little coping capacity would have more difficulty caring for themselves and their children, and we hypothesized that the benefits of the program in Memphis would be greater for those women.

We also saw during the first 4 years of the child's life that there was a significant reduction in the rates of subsequent pregnancy for unmarried women with low incomes and an 84% increase in the rate of employment. There were very few benefits for women who were of higher social class and who were married. That is important to keep in mind.

In the 15-year follow-up that we just completed in Elmira, we found that there was about a 33% reduction, about a half-child reduction, in the rates for subsequent live births in the first 15-year period after the birth of the first child. There was a 30-month treatment versus control difference in their rate of AFDC use. There was a 44% reduction in women's own behavioral problems due to involvement with alcohol and drugs. These results are all concentrated on unmarried women with low incomes. We also see an even larger reduction in their rates of arrests. We think that this has to do with these women's significant alterations of their life-course trajectories. Many women were living in households where they were exposed to violence, drug use, and criminal activity. They were often at a stage where they had youthful idealism and hope for themselves and their babies. Having a nurse come into their home and give them concrete skills to bring that to life could start to explain why 15 years later we would start to see effects like this.

Fifteen years after the birth of the first child, there was a 79% treatment/control difference in the number of state-verified reports of child abuse and neglect for unmarried women with low incomes. There was also a reduction in their use of cigarettes and alcohol by the time the children were 15 years old. The reduction in alcohol is important because children who begin to use alcohol by 15 are four times more likely to become alcoholics as young adults compared to their counterparts who abstain from drinking until they reach 21.

These long-term effects on child abuse, criminal behavior, and alcohol use are increasingly replicated in studies of rhesus monkeys in the NIH primate laboratory. Those studies have shown that aberrant rearing early in life can interact with genetic vulnerabilities for these problems and increase the likelihood that the genetic predisposition is going to be expressed. So, we think that there is a biological basis for the kinds of things that we are seeing here.

Recently, the Rand Corporation conducted an economic evaluation that shows that over the life course, the cost of the program for low-income, unmarried women has been recovered four times over in terms of reduced government expenditures.

In Memphis, we reproduced the Elmira study, but focused the sample on low-income, unmarried women. This was more of what we call an effectiveness study. We conducted the study in Memphis at the height of a nursing shortage, which meant that we had about 50% staff turnover because they could walk across the street to a hospital and earn $3-4 more an hour. We could not compete.

We found that many of the most important findings from Elmira had been reproduced. I am only going to highlight a couple of them here. We knew in Memphis that we would not see

reductions in the rates of state-verified cases of child abuse and neglect because we did pretest and pilot work that showed that the rates of state-verified cases of child abuse and neglect were only 3–4%, much too low for us to be able to detect changes with the sample sizes that we had, given whatever referral and reporting mechanisms were being used.

We did expect to see effects on health care encounters where injuries were detected among the children that would reflect what we had seen in Elmira. We found a 20-25% reduction in the rates of injuries, and that percentage reduction is concentrated in women with few psychological resources, that is, a limited sense of control, limited intellectual functioning, and greater mental health symptomatology. Replication of the pattern of findings gives us confidence that we really do know more about how the program is working and for whom it is working. In addition, that finding is also replicated when we look at the number of days the children are hospitalized with injuries. This represents about an 80% reduction in the number of days that children are hospitalized with injuries. The treatment/control difference is much greater among women who have few psychological resources at registration prior to randomization. Again, we see a replication of the pattern we saw in Elmira.

There were three cases of children with injuries who were hospitalized in Elmira in the nurse-visited condition. What I want you to focus on now is the age and the diagnoses. These children were all 12 months of age or older. That is, they were mobile, they were up and getting into things. Two of the three cases involved ingestions. In the third case, a child picked up an iron on his grandmother's bed where she had been ironing and put it on his face.

Now, let us look at the cases in the control group. The rates are higher. What I want you to focus on again is the age and the diagnoses. More than 40% of these children were hospitalized before 6 months of age. The diagnoses were significant head trauma, fractured long bones, bilateral subdural hematomas, and fractured skulls.

We are talking about very different profiles of injury in this population. While we do not see the effects replicated in state-verified reports of child abuse and neglect, we do see the pattern revealed in the injuries that are detected in the children's medical records.

These findings gave us confidence that this is a program where the effects could be reproduced. By this time, we had finally reached a point where we felt that we understood the clinical elements of the program and had articulated them adequately. We could now start to share those program procedures with new communities.

Therefore, we were invited a few years ago by the U.S. Justice Department to set up the program in some high-crime communities around the country. We accepted that invitation in part because we wanted to understand what we considered to be the next set of research issues in this area. How do we translate these research findings into effective practice in communities?

Oftentimes these programs get watered down and compromised in the process of being scaled up. We knew that we had something that worked, but we were concerned that once we put it out into the community, we would have legislators who might say that the nurses have a cushy job and that they should be assigned 60, 70, or 100 families as opposed to 25. They also might say that they do not like the fact that we begin during pregnancy or serve families with more than one child, and so forth. We want to study what it takes to maintain the fidelity of this program as it moves into real-life communities today.

■ A Portrait of America's Children: Transcultural Child Psychiatry

Gloria Johnson-Powell

I am going to talk about some of the practices needed in child mental health service delivery to address the needs of children and families, with a particular focus on the diverse population of

children we serve. This will include the ecological and psychosocial cultural factors and the assessment of developmental outcomes.

With the rapidly increasing diversity of the U.S. population, children and families with different cultural, ethnic, and linguistic backgrounds from every corner of the globe may be found in our schools and in our health and human service agencies. However, there has not been much attention to or research on the role of cultural context in the assessment of the development of these children, despite such studies in the anthropological field.

In the first book on child psychiatry on this issue that we published, *The Psychosocial Development of Minority Group Children*, Sinclair wrote a chapter on bilingual education. The assessment and treatment of cultural and linguistically diverse children has been addressed in service delivery, but rarely in training programs. Our new book, *Transcultural Child Development*, was put together with funds from the van Ameringen Foundation.

My experience clinically in child psychiatry has spanned several continents in several years. I am trying to put together information to train people, professionals, and parents, about cultural diversity and the issues of children's services, particularly children's mental health services. This is a culmination of my experience in academic medicine and in clinical settings in Guatemala, Brazil, and several places in Africa, especially Uganda where I served as a mental health consultant for the international school there, which had more than 25 countries represented and Tanzania, where the international school had 50 different countries represented.

It was a great challenge for me to try to begin to deliver mental health services to this vast array of children. The clinical experience that I am going to share comes from my own clinical experience as the child psychiatrist, pediatrician, and neurologist. At the Dar es Salaam School of Medicine in Tanzania, they said you have an "IBA" degree: "I've Been to America." You are supposed to be able to do everything.

In the update of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the National Institute of Mental Health convened a special task force to examine the cultural appropriateness of the diagnostic categories. The publication of the findings is a significant contribution to the mental health assessment process and diagnosis, although many of us bemoan the fact that it did not go far enough. However, the application of cross-cultural, psychological, and psychiatric assessments of children still lag behind that for adults, due to the lack of research on the cultural influences of developmental psychopathology. The bridge between the cultural and the mental health assessment of children and adolescents is based on four basic premises:

1. Culture is the context or environment in which various kinds of behavior are developed and expressed.
2. Both the context and the content of learning from birth through childhood and adolescence are distinctly cultural.
3. The child's early experiences as a member of an ethnic, racial, or cultural group are significant in shaping behavior, organizing and expressing emotions, and discovering ways to meet social and emotional needs.
4. Information about each racial, ethnic, or cultural group is necessary to understand in order to provide culturally relevant assessment and treatment.

How do you implement relevant treatment? It is not as easy as one might think. I have been trying to do it for 40 years and I am still stumbling, so I will share that with you.

Let us first take a look at why it is so complex. Children are embedded in a complex system that includes factors within the child, the parent, the marriage, the work networks of the parent, the social networks of the child and the parent, the school network, the community, the society, and the culture. For us to look at only one system, parent to child, is insufficient for an understanding of all of the factors that impact upon the child's development.

There are many of us in the women's research area who have bemoaned the emphasis there has been in child psychiatry on the "mal de la mere." That is, everything that goes wrong with

the child is because of something that did not go right with the mother. We who are mothers and fathers understand that we live in a broader context that can have an impact on our child's development as it has an impact on us and our families.

Clinicians and service providers cannot rely on stereotypes of racial, ethnic, or cultural groups but must have knowledge about the social and cultural context in which different groups of children grow and learn, recognizing that differences are not deficits.

Let me tell you about the big mistake that I made when I went to Ethiopia in 1962, bright-eyed, bushy-tailed, and straight from the civil rights movement and medical school, to work as a physician. I had not even done my internship, but once again, they said, "You have an IBA." That is, I had been to America so I could do everything.

Before I knew it, I was working at a woman's hospital doing fistula repairs and working at the Ethiopian Swedish Pediatric Clinic. You have to understand the ecology of Ethiopia to understand how brazen I was to think that I could deliver services in the context in which they were occurring. At a pediatric clinic, there were children with infectious diseases. Incredible illness, sickness, and disability were occurring in Ethiopia because of the socioeconomic status of the country and the lack of development. Most mornings I might have enough penicillin to treat two children adequately.

I noticed that if children were 5 years old or younger, they came dressed in gunnysacks with bare feet. Also, the parents shaved the children's heads, so one could not tell who was a boy or a girl. Yet the parents who would bring the children to the clinic would be dressed in long dresses, sweaters, head-coverings, and boots. I hoped that my disdain for the parents would not show, and I would think of my mother who always would make certain that we were dressed warmly.

After a couple of months, I asked a mother the question that was on my mind, and hoped that it would not be offensive. "Why is it that your young children are dressed this way?" The answer came back, "So that the child can be snatched more easily away to heaven."

The childhood mortality in Ethiopia was more than 50%, which meant that a family could not afford to invest in warm clothing for a child until they knew that the child would live. The gross national income per capita was about $10 a year so a child was a major expense. Therefore, only older children, past 5 years of age, were clothed. Parents would shave their hair to prevent the head lice from disturbing the children.

Certainly that was an expression of love just as how my mother raised us was an expression of love, but in a different context with a different reality and with different ecological and cultural circumstances. They used their religious beliefs to help them cope with their children's deaths and to sustain those children who would live. They prayed and hoped that their children would not suffer and that they could give enough to those who had the resiliency to survive.

That is a different concept than we have, but nonetheless, it is a caring, loving concept. Who was I with my western view, even though my face was dark skinned and I looked like an Ethiopian, to judge these mothers and fathers. That has always been an important lesson to me, and it is one of the reasons I became interested in the cultural differences in child rearing and how that related to psychological development and psychopathology.

New evidence suggests that psychological development among children is a function of universal cognitive and emotional stages as well as symbolic systems that are themselves dependent on both ecological and psychosocial cultural variables. Erickson as well as Fromm and Bowlby, realized that many social influences, above and beyond the impact of the family, served as necessary integrative influences on the developing child. Bronfenbrenner and others have emphasized the importance of context in influencing the course and outcome of the development of the child.

These broader views revolutionized social scientists' views of human development with greater emphasis on social and cultural factors, with social and ecological factors intrinsically related to cultural infrastructures. The understanding of cultural concepts in the facilitation of optimal child development as well as developmental dysfunction or psychopathology has

enhanced the conceptualization of human development as a function both of biology of the organism and the individual's psychological, social, and cultural environment.

Because an individual's personality is a function not only of biology and family dynamics, but also of the social worldview, which may be different from the one we have, the relationship between culture and personality may be difficult to discern. Many times when we are stereotyping various ethnic or racial groups, what we are doing is looking at what we think their personalities are, not realizing that these are social customs that are derived from their culture.

For instance, a young man from Ethiopia came to see me while I was at UCLA. Because he considered me high-placed because of my education, he bowed frequently, and when he left the room, he bowed again and backed out. A colleague nearby commented on how obsequious he was. I told him that he did not know that the young man was paying us the greatest honor, honoring our knowledge, status in this society, and ability to convey knowledge to him. He came from a wealthy family and was well educated. His bowing out of the room backwards was not an expression of obsequiousness, but of utmost admiration and respect for what we were saying and our willingness to have him in our program. Therefore, you can see that if you enter into a relationship with a colleague or a student thinking that their manner is obsequious rather than a way of showing respect for you, then the way in which you will interact with them will be different.

These concepts of contextual variation among children argue for a multicultural, multifaceted, longitudinal approach to the assessment of developmental outcomes. Therefore, what is the culturologic assessment, as I call it? Everybody says be culturally competent. How do you get to be culturally competent? I am still trying to be culturally competent. It is a long process. By the way, in order to become culturally competent in the same way that one may become medically competent, competent with social service skills, or competent in evaluating children, you have to read. There is nothing that will substitute.

For example, if one is trying to figure out what drug to use for a child, one goes immediately to the psychopharmacology book and looks at all the possible reactions to determine which is suitable for the child. One tries to read up on it before seeing the child. The same holds true if one has a family who is culturally different, and one does not know the culture. One must take the time to read. That is equally as important as learning the growth and development according to the pediatric charts or knowing what drug to give.

If one reads about the culture, the biology, and the social and cultural aspects of the client's circumstances, then maybe there will not be a mismatch, such as giving pharmacological substances to cure something that will actually kill. For example, because the doctors at a prominent Boston hospital did not understand that African American boys are very sensitive to Dilantin and get Dilantin toxicity very early, my 13-year-old nephew died. If one does not understand that Asian American children are very sensitive to psychotropic medication, one may overmedicate them, and then because of the overmedication, they may display symptoms that are even more bizarre. Then, because they are acting more bizarre, they are given more of the drug.

If culture provides the context in which various kinds of behavior are developed, then we know that the absence of well-being is expressed differently among different cultural groups. Recent research has established some of the different cultural ways of expressing illness or discomfort and how psychiatric symptoms are, in part, reflections of culturally learned behavior. Consequently, cultural attitudes and beliefs often determine the type of health care sought by parents for their children as well as the meaning given to the child's symptoms by family members.

The culturologic assessment attempts to include the cultural, social, and linguistic issues that are pertinent for a multicultural population of children and families. There are several steps to doing a culturologic interview. One is entering the world of the client. To enter the Ethiopians' world, I learned some Amharic words. I found that even though I pronounced them incorrectly,

mothers and children enjoyed hearing me try. They would try to correct me, and in that exchange of their trying to correct me and my trying to say it right and my saying it wrong and their giggling, we began to make some contact. They at least felt that I was trying to enter their world.

The second is shaping the content and context of the interviews. Let me give you an example. When I first went to be interviewed by the Dean of Harvard Medical School, it was at 9 o'clock in the morning, and he had a big table filled with food. It looked like he was going to have a group meeting. It turned out that it was all for me, and he was trying to decrease the social distance.

There are many ways that you can decrease the social distance. I decrease it by saying that I am a grandparent now or that I am a mother and talking about my children. Each of you will find your own way.

Increase the perception of sameness by doing that. For Asian American patients, especially for Chinese, one of the things that you might do is bring them a gift, because bringing a gift to a Chinese family means that you understand them and you are ready to welcome them. You have to find those clues. Elicit as much information at each contact depending on the level of comfort.

What is the important data that you have to get now that you have decreased the social distance and increased the perception of sameness? You need to know something about the country of origin. If you do not know anything about El Salvador, go to your computer and pull some information up on the screen and read about it. At least know something that you can use to reach somebody with. You need to know the reason for migration. As we read immigration history, there are many reasons why people come, and they come in different waves: the length of time in this country, the number of generations in this country, and the language spoken and where. For instance, Vietnamese children end up speaking Chinese, Vietnamese, and English. However, when do they speak those languages and where? Which is the predominant language?

What is the family and kinship network? What are the religious beliefs and beliefs about causality? What are the child rearing practices? How are the sex roles different? What is expected of women, and what is expected of men? What is expected of an adolescent child? What is expected of a preschool child? In what kind of community are they living? Are they living in integrated or segregated communities? Are they living in a mixed community of immigrants from all over the world?

What is the life space like? You want to step inside the world of the child. What does the child see when he wakes up in the morning? Does he see a great big hole in the ceiling? What kind of sounds does he hear? Does he hear railroad trains or does he hear the sound of birds? Can you step into the life space that that child occupies and know what he experiences from one moment to another or at least get a sense of it? What about the overt and covert reasons that the parents have for seeking help?

I have gotten into many binds relying just on the parent. So many times I have had parents who present a child they think is having problems but who really is not having problems; the child is having problems with the parents because the parent is not functioning well. Can you describe the help-seeking behavior of the child and the parents? What is the educational attainment of the parents? What is their country of origin? What is their current occupation? What are their experiences with rejection? There are people who come to the U.S. who are considered very important in their own country.

For instance, in the book we have a chapter about West Africans, particularly Nigerians. One of the reasons they leave the U.S. so often is that they have been in the majority culture in their own country, and they find it very difficult to take the racism that they experience once they come here and to be pushed into feeling inferior. However, it not only happens to Africans but also to many groups who come and find the racism so vicious and so lowering of their self-esteem.

What is the degree of acculturation? How do you assess that? By the food they eat, their dress,

their social activities? Not everybody in the family acculturates at the same rate. There are lag periods, and some are way ahead and some are far behind. That may create certain kinds of issues in the family, the degree of cultural conflicts that the parents are experiencing. We talk about getting the clinical history, but it is crucial that you mix the clinical history with the cultural formulation and the cultural history.

For instance, by the time you finish your evaluations, you should have some concept of what the cultural identity of the family is in terms of their language and all the other factors. What are their cultural explanations for the illness? What are the cultural factors related to their psychosocial environment and their levels of functioning? That is where you get a basic understanding of how they are functioning in this new world, this new environment.

You must look at the cultural elements of the clinician/patient relationship before you can do the overall cultural assessment, because maybe they are reacting to you because you have not been able to relate to them in a cultural way. The assessment process should yield the kind of data that have been described in these questions and more in order to begin to consider the diagnostic categories or the description of the dysfunctional behaviors.

Camino found that the DSM-IV Axis IV (the severity of psychosocial stresses) and Axis V (the global assessment of functioning) are essential components of the diagnostic classification of culturally diverse children. She asserts that the diversity of symptom expression and the multiple cultural pathways in developmental psychopathology often result in overdiagnosis on Axes I and II. Therefore, we have a tendency to overdiagnose culturally different children.

Camino found that by using the Global Assessment Scale for Children she was better able to determine who needed treatment and who did not. When only Axis I of the DSM-IV was used, 49.5% of the Puerto Rican children were diagnosed as needing mental health services. This is highly unlikely. When the Global Assessment Scale was used, there were children who really did not need treatment among that 49.5%, who were not severely impaired, and that the seemingly high prevalence of psychiatric morbidity could have reflected the higher levels of stress.

Finally, and most importantly, transcultural child psychiatry is concerned about the impact of cultural beliefs and practices on the development of the psychological well-being of children as well as the development of psychopathology. These include cultural beliefs and practices, child rearing practices, the relationship of the child to the caregiver, and the caregiver's transmission of cultural values and beliefs. When socialization occurs in a society in which the culture of a child is different from the dominant society, the process of socialization and acculturation may be very stressful for children and families.

Our experience overseas led us to have our children, instead of saluting the flag, say something that we felt was very important. It has to be a statement for Head Start as well to provide services for the whole universe of children and families. We are not made for one corner of the earth; the whole world has to be our native land.

Brenda Jones Harden: I am going to talk as a practitioner, researcher, and program administrator, as I have had all of those roles at some point in my career. I would like to share some thoughts from the practitioner's perspective. I have a list of issues:

1. The high cost of working with families and children. Although everybody has told us about the importance of doing it and doing it from a system of care perspective, knowing what to do and understanding the cultural issues is exhausting. As a home visitor, as a clinician, I have been worn out. Now I can only do two home visits a day as a result. I want to encourage everybody to think about taking care of the practitioners who are out on the front lines doing home visits.
2. The timing and target of service. Olds' work most succinctly gives us some answers. This is particularly relevant for those of you who are working in early Head Start programs. There is a reason that performance standards talk about starting in pregnancy. What we do to a large extent is start services after the birth of the child. I have echoes of Helen Taylor's

voice in my head, as she said this is a child development program. There is a reason she keeps saying that. Olds has done work with nurses helping mothers to think about their children. All of us in Head Start have to think about the same thing. When we get overwhelmed with mothers' problems, we have to go back to the child development arena.

3. The importance and challenge of parent involvement. Twenty years ago, it was much easier to get parents involved. As we think about changing our programs and changing our practice, we need to think about making parents partners in the process.
4. The reflection of culture of different minority groups. I do not know about you, but I cannot keep up. I cannot learn the 50 languages that I have to learn. We visited one Head Start program where they had 50 different cultures represented. We will never learn 50 different languages, but if we at least show respect and a willingness to open ourselves up to a different way of being, we do not have to have all the language skills.
5. Cultural perspectives on mental health diagnoses and need for treatment. We need to open ourselves up to understanding that what we see as psychopathology may not be what somebody else sees as psychopathology. We need knowledge and skills. As a practitioner, especially when we are thinking about the kind of comprehensive approaches that Leaf and Olds talked about, we do not just have to know about how to be a good home visitor, we have to know about neural development, health, and self-sufficiency issues. I challenge anybody who is an administrator to think about the enormity of the task for a frontline person to have all that in his or her head. As we think about supporting practitioners to do this work, we have to be the vehicle in which they receive this kind of training.
6. The overwhelming impact of larger structural variables. I always think about that as I hear about interventions that work. We have a monster here that is hard for us as direct service providers to get a handle on. What do we do about poverty? The way I think about it is that I can only do so much. There are certain things that I will not be able to impact, but I can, through my relationship with the family, change some of their parent/child relationships, and so forth.
7. The influence of funding. From a program administrator's perspective, funding has a lot to do with what kind of personnel we hire. Olds talked about his new study in which he is going to look at home visitation from nurse home visitors and from paraprofessionals. We know that if we offer more training, we have more professionalism. A lot of times we do not have the money. One of the things that we can think about, however, is that even though people may not have a certain degree, they can be trained. Staff can become, as the Healthy Families group in this area calls it, "nondegree professionals," so that they end up with almost the same level of skill as some of the professionals.
8. The cost of the delivery of comprehensive services. Clearly from an administrator's point of view, one tries to provide a system of care where one is trying to meet families at all levels. Therefore, we must think about pulling in as many community resources as possible. Oftentimes we get overwhelmed, particularly in Head Start as a comprehensive program, with the enormity of the task before us. Knowing our roles and saying this is what we do best is important. For example, if we do not have enough substance abuse beds, we just have to say we are doing the best we can.
9. The challenge of community partnerships. From an administrator's point of view, it takes many of us to try to get people to think like we do. One of the things that I think about often is the child care issue and how we have to convince them to meet Head Start Performance Standards. There is a lot of work we have to do to make it a priority. Perhaps using some kind of model in the way Leaf does will help us do that.
10. Competition between service delivery and evaluation. Obviously, there is this tension. We only have a little bit of money. How much do we put in evaluation, and how much do we

put in service delivery? Most of us from administration and practitioner points of view would say we must serve families, but if we are serving families and it is not doing anything, why are we doing it? I want to emphasize the importance of a continuous improvement focus. Evaluation is not just for somebody to get tenure. Certainly from a program evaluation perspective, how we spend our money is an important issue. If you are struggling with this tension, think about it as a way to survive, as a way to ensure that your program is doing what it is supposed to be doing.

11. The training and supervision of staff regarding cultural and mental health issues. The Performance Standards specifically state that we are supposed to have culturally sensitive interventions, mental health professionals onsite, and staff training. However, oftentimes the training is not done. We have to stop and say that this has to be a priority.
12. Staff retention. We must think about that as a concrete goal. If we cannot pay staff, we have to do whatever else we can to keep them.
13. Program design informed by the literature, culture, and performance standards. We need to stop creating programs in our heads. The best thing to do is go to the data, look at what has been found, and then have your program designed around that.
14. The beauty and cost of elegant research designs. From a program person's perspective there is a cost to that. One thing that we all are struggling with is what to do with the people who do not get into the treatment group. As a clinician, that is always an issue. One of the solutions is treatment partitioning designs where you give some portion of the treatment to everyone. Talk to researchers about how they can come up with designs that meet your needs and that do not make you feel like you are depriving your clients of service.
15. Community replicability of research-driven interventions. Any research that comes to us that does not show that it can be replicated in our communities should not be accepted.
16. Measurement of hard-to-operationalize processes and outcomes. One of our problems is that the things we do best are harder to operationalize. For example, what if you ask one of your families what has benefited them the most, and they say, "Miss Smith. She was nice to me." That is an important piece of information. Psychotherapy effectiveness research tells us that "relationship" predicts outcomes. One of the things we can help researchers do is think about the nuances, the things that we know make a difference in our programs, and help them shape how to measure those. We do not have to always use nationally standardized measures. You need them, but there are others that can supplement them.
17. Culturally relevant assessment procedures. We need to challenge researchers to move away from measures that have been standardized on populations that are not reflective of our own.
18. Program fidelity. You have a wonderful intervention, it is supported by data, you have your evaluation team on board, and your practitioners do not do what they are supposed to do. One thing that should happen in supervision is making sure classroom teachers and home visitors do what we expect them to do.

Improving Outcomes for Young Children of Criminal Offenders Through Integration of Policy, Research, and Practice

CHAIR: Creasie Finney Hairston
PRESENTERS: Barbara Bloom, Creasie Finney Hairston, Susan Phillips

There are more than 5 million children in the United States with a parent in jail, in prison, on probation, or on parole. Within this population, children of prisoners have received the most attention, yet there have been no systemwide or long-term studies of their development, behavior, or criminal justice involvement; research has largely been limited to surveys of their parents. Similarly, public policy has viewed criminal offenders in isolation from their families, although all stages of the justice process affect offender-family relationships. The first paper in this symposium presents an overview of public policy on children of criminal offenders and reviews the relationship of uninformed policy to programming that often fails to address these children's most critical needs. The second paper reviews the recent developmental approach to research on children of criminal offenders and findings describing their characteristics and service needs. New data on childhood trauma and the relationship of recurrent episodes of multiple different types of trauma to child development and criminal behavior appear to be important to the planning of intergenerational services for families of criminal offenders. The third paper presents a collaborative model of prevention and intervention services for children of women prisoners and their caregivers based upon this research. The panel examines the interaction of policy, research, and practice in creating model services that improve developmental outcomes for the population of young children most likely to become involved in delinquency, adult crime, and/or incarceration.

■ Public Policy and Children of Criminal Offenders

Barbara Bloom

There are more than 5 million children in the United States with a parent in jail, in prison, on probation, or on parole. More than half of these children are under 5 years of age and another third are 5 to 9 years old.

The large size of this unrecognized population is the result of increases in U.S. incarceration rates since 1960, primarily due to the war on drugs and mandatory minimum sentencing laws. Most persons under correctional supervision in the United States are parents, yet public policy has historically viewed and treated criminal offenders in isolation from their families. Children, in particular, are affected negatively by all stages of the justice process, including parental arrest, adjudication, and incarceration. A wide range of criminal justice practices, from the management of children present at arrest to the design of jail visiting room environments, have been found to have a significant impact on these children. Policies such as longer prison sentences and statutory limitations on judicial discretion to consider family factors in sentencing have increased the negative effects of legal sanctions on offenders' children.

In spite of these circumstances, there is a lack of objective information about these children. There has been no direct measurement of their numbers, ages, or living situations or longitudinal research on their developmental or criminal justice outcomes. Nonetheless, programs and policies are being implemented on behalf of these children throughout the United States.

Nationally, there is a wide range of policies affecting children of criminal offenders. Law enforcement management of parental arrest varies from no policy at all in 99% of jurisdictions

to comprehensive, collaborative research-based programs of intervention and treatment. Correctional policies for management of pregnant prisoners vary from no services to mother-child community-based correctional programming to prison nurseries. Child welfare guidelines for families of criminal offenders also vary widely; most agencies provide workers with little or no guidance, while others provide comprehensive packages of policy and resource materials. Court-ordered terminations of parental rights among prisoners occur at high rates nationally, but the legal framework for such actions varies widely by state. Policies on parent-child visitation often vary by jail or prison; with some offering well-designed play areas for visiting children, parent-child visitation centers, or even overnight visiting, and others in the same jurisdiction offering no child-related services at all.

Both the lack of research and the lack of application of existing research findings have produced this disarray in programming. The absence of coordination of research and policy also limits the availability of high quality services for children of criminal offenders. Teachers, for example, may work with families from two or more criminal justice or correctional jurisdictions but have no way of informing themselves systematically about the issues and needs of children of criminal offenders in each of these jurisdictions.

This presentation summarizes public policy related to children of criminal offenders and provides recommendations for judicial, legislative, and administrative changes in the criminal justice and child welfare systems that would improve outcomes for these special children.

■ Research on Children of Criminal Offenders

Denise Johnston

Research on children of criminal offenders has been limited by lack of interest and situational factors, such as difficulty in identifying representative study samples. Early surveys of incarcerated parents primarily examined child welfare issues, finding that most of their children lived with single and/or elderly female caregivers. Influenced by the women's movement and dramatic increases in female incarcerations, the next wave of research presented anecdotal evidence of the negative effects of mother-child separations on children of prisoners and statistical support for the inverse relationship of maternal recidivism to family reunification.

Other studies found that only a small minority of incarcerated parents had children in foster care. However, these prisoners often had difficulty understanding and meeting the prerequisite conditions for permanency planning. They were most likely to retain or regain child custody when their children were placed with the prisoners' own mothers. The largest proportion of termination of parental rights in the United States occurs among prisoners who have children in foster care.

Later research found that offenders' families typically had high levels of stress, histories of compulsive behavior problems and criminal activity, and limited access to resources; as a result, they were unable to provide children with an adequate level of emotional and material support. In spite of multiple stressors and separations, these families had strong and resilient intergenerational bonds.

Only recently have children of criminal offenders been examined as index subjects of research. Investigators have found that from 19 to 45% of children of women offenders were present at their mother's arrest and that the great majority of prisoners' children are aware of parental incarceration. Studies of older children identified school problems, delinquency, and characteristic patterns of legal socialization.

The first large-scale, longitudinal study of children of criminal offenders in the United States found them to be distinguished by: (a) an inadequate quality of care, largely due to poverty; (b) a lack of family support, largely due to high levels of stress and parent-child separations; and

(c) the experience of childhood trauma. The study found that children of criminal offenders typically have had, and are at risk for, one or more traumatic experiences; enduring trauma, defined as recurrent episodes of two or more types of trauma throughout at least one developmental stage of childhood. This type of trauma occurred in 10 to 20% of those studied and most commonly among those children whose behaviors appeared to be leading them toward early entry into the criminal justice system.

A large body of research documents an intergenerational pattern of criminal behavior. Studies have found rates of parental incarceration among prisoners ranging from 8 to 51%. The lifetime risk of incarceration among children of prisoners is at least 25 to 30%, several times higher than the U.S. average.

Children of criminal offenders appear to have characteristic patterns of development. At each stage of their development, the effects of trauma, inadequate material care, and lack of family support interact with their efforts to achieve major developmental tasks, producing their characteristic behavioral outcomes. While these outcomes appear to be adaptive in the environments in which children of criminal offenders are raised, they also lead to criminal justice system involvement.

■ Applying Research to Programming for Children of Criminal Offenders

Susan Phillips

Historically, the interrelatedness of criminal justice policy and the well-being of children and families has been broadly overlooked. This is particularly the case when mothers are incarcerated. This paper presents a collaborative model of prevention and intervention for children of prisoners living with someone other than a parent.

In 1988, the U.S. Bureau of Justice Statistics reported that more than half of the children in state-run institutions had experienced the incarceration of a parent (U.S. Department of Justice). Research examining intergenerational crime and incarceration suggests that the factor children of criminal offenders most often share with their incarcerated parents is the experience of enduring trauma. The causes of enduring trauma, defined as the recurrent experience of multiple types of trauma throughout at least one stage of development, are not limited to the traumatic effects of parental crime and incarceration. Other traumas experienced by children of criminal offenders are related to systemic barriers that prevent the caregivers of these children from accessing assistance to meet basic family needs.

This paper presents both quantitative and qualitative data from multiple studies and needs assessments of children living with relatives during parental incarceration, including data collected from a model project. These reports describe the demographics of the population and the problems commonly experienced by caregivers of the children of criminal offenders. This data will be compared to national statistics on relative-headed households.

The model project presented is grounded in the theory of enduring trauma and its intergenerational effects within families of criminal offenders. The goals of the project are to enable children to receive services that reduce the effects of trauma experienced prior to maternal arrest and to enable caregivers to provide a stable home for participating children, reducing further trauma during maternal incarceration. The project provides crisis intervention, advocacy for individual families, support groups for caregivers, and therapeutic interventions for children. Project activities form the basis of a continuum of services, which also includes parent education and domestic violence groups for incarcerated mothers, transportation for children to visit their mothers in prison, and public education.

The sponsoring organization has worked with the population of incarcerated parents since 1991 and has involved advocacy groups, behavioral health systems, religious groups, and state agencies in addressing the needs of the families of criminal offenders. The number and types of interventions provided by the model program have grown as participating organizations have learned more about incarcerated mothers and their children.

This presentation will describe the structural elements of the model program, how program services have been shaped by current research on children of criminal offenders, and the applications of program experiences to public policy relating to these children.

Reference

U.S. Department of Justice. (1988). *Survey of youth in custody, 1987.* NCJ113365. Washington, DC: Bureau of Justice Statistics.

Evaluating the Healthy Steps for Young Children Program

CHAIR: Bernard Guyer
DISCUSSANT: Kathryn E. Barnard
PRESENTERS: Kathryn T. McLearn, Bernard Guyer, Margaret Caughy

The Healthy Steps for Young Children (HS) program, an initiative of the Commonwealth Fund, seeks to enhance the developmental potential of young children (birth to 3 years of age) and to strengthen the involvement of parents in their children's early development by reorienting the practice of pediatrics to emphasize child development and parenting competence. The Healthy Steps program is developing and testing a new model of pediatric practice designed to achieve this goal. A significant component of this model is the inclusion in pediatric care of a new health care professional with a focus on child development, the Healthy Steps Specialist (HSS).

The first paper in this symposium will describe the rationale behind the Healthy Steps program and its major features. The second paper will describe the design of the national evaluation of Healthy Steps. The third paper will present the results from the formative evaluation and the available results from the first year of the national evaluation, including descriptions of the sites and participating families.

■ The Healthy Steps for Young Children Program

Kathryn T. McLearn, Barry Zuckerman, Margot Kaplan-Sanoff, Steven Parker, Michele Yellowitz

The importance of the first 3 years of life is the focus of a new national initiative, the Healthy Steps for Young Children (HS) program. Pediatricians from Boston University in collaboration with professionals from the Commonwealth Fund developed the HS program. The Commonwealth Fund launched Healthy Steps in 1994 and has since partnered with more than 50 funders. Currently, there are 15 evaluation sites and 9 affiliate sites, which, over the life of the project, will serve more than 3,500 families.

The Healthy Steps for Young Children program responds to several important realities of modern American life. First, HS meets the needs of the changing dynamics of U.S. families: more mothers in the work force. Families have fewer children and less experience with raising children and grandparents are generally not available. Families need advice on children's issues. Second, pediatricians, particularly with the new pressures of managed care, do not have adequate time or contact with parents to address developmental concerns. Finally, new research on early brain development emphasizes the importance of the early infant's family environment to maximize learning potential. The program is grounded in the assumption that parent education has an effect on families and children. Also fundamental to the Healthy Steps strategy is the belief that the health care system is the best place to locate this type of early intervention on behalf of children.

The Healthy Steps approach has three underlying premises: (a) the first 3 years of life are critical for both the child and family, (b) relationships between parents and children are key to healthy growth and development, and (c) an expanded approach to pediatric care that centers on the child's health as a whole and that strengthens relationships is needed.

The program calls for new members to be added to pediatric teams—Healthy Steps Specialists—who have special training in child development and who become the families' primary resource. The Healthy Steps Specialist's role includes: office visits, home visits, assessment of

developmental progress, helping parents manage behavioral concerns, providing community links, parent groups, staffing the Telephone Information Line, and coordinating Reach Out and Read. To these ends, Healthy Steps is comprised of the following components:

1. Enhanced strategies in well-child care: (a) Teachable moments enable pediatricians and Healthy Steps Specialists to draw on observations of child and parents to communicate information about behavior and temperament. (b) Healthy Steps promotes early learning in recognition that reading and talking to young children are critical factors in their readiness to learn and in language development. Therefore, Reach Out and Read activities are incorporated into the practice.
2. Child development assessment check-ups are done every 6 months by the Healthy Steps Specialists to detect developmental or behavioral problems and provide teachable moments.
3. Home visits are timed to reach parent and child at junctures in their developing relationships in an environment where parents often feel more comfortable about voicing concerns.
4. Written materials emphasizing prevention include: (a) LINK letters, (b) office prompt sheets, (c) a Child Health and Development Record, and (d) parent handouts on a variety of topics.
5. Healthy Steps Specialists who answer questions about child development or behavior issues staff the Healthy Steps Telephone Information Line.
6. Parent Groups, led by the Healthy Steps Specialists, are provided at office sites and are designed to interweave information and support.
7. An updated bulletin board with information for parents and a directory of community resources provide linkages to community resources.

In order to use the Healthy Steps components to successfully transform practices into an interdisciplinary Healthy Steps approach, pediatric clinicians and Healthy Steps Specialists are trained by the Boston University School of Medicine. The training includes interactive strategies and case-based problem solving. After the training, Healthy Steps Specialists participate in biweekly technical assistance calls with the Boston team.

■ The Design of the National Healthy Steps Evaluation

Bernard Guyer, Nancy Hughart, Margaret Caughy, Donna Strobino, Alison Jones, Dan Scharfstein

The goal of the national evaluation of the Healthy Steps (HS) program is to assess whether HS is successful in reorienting pediatric practice to emphasize child development issues by increasing parents' knowledge about early nurturing of infants, involving parents more in their children's development, and promoting parental practices that improve the health, safety, and health care utilization of their children. The evaluation has five components:

1. The formative evaluation, completed in the first 4 months, provided feedback for refining the Healthy Steps intervention, the evaluation design, and the data collection instruments and procedures.
2. The process evaluation documents the context of the Healthy Steps intervention, including the population served, the institutions and providers involved, and the broader political and financial policy environments. It provides information regarding the types of HS services provided, to whom they are provided, and the extent to which the services provided are consistent with the program plan. The process evaluation documents the extent to which providers practice change. There are five sources of data for the process

evaluation, including the site-planning documents, key informant interviews, participant observation, enrollment data, and provider surveys.

3. The outcome evaluation assesses whether HS has an effect on the knowledge, attitudes, and behavior of providers. It evaluates the impact of HS on parents' knowledge, beliefs, and practices regarding parenting and on their understanding of early child development. The evaluation will assess the effects of HS on intermediate outcomes, such as the utilization of health services and parental adoption of health and safety activities, and on parental satisfaction with pediatric care. Finally, the evaluation assesses the effect of HS on parameters of children's health and development. Data sources for the outcome evaluation include periodic provider surveys, brief standardized forms completed by Healthy Steps parents at office visits, interviews with Healthy Steps parents, and medical record reviews.
4. The economic analysis evaluates the cost effectiveness of HS, including direct costs, indirect costs, and cost savings. The cost effectiveness of HS from the parents' perspective and that of participating providers will be assessed.
5. Finally, an assessment of the potential for institutionalization will also be carried out. The overall goal of assessing the potential for adoption of HS into pediatric practice is to look beyond the immediate limits of the HS program to the implications of this national experience for the future of infant and child health care.

Structure of the evaluation: The Healthy Steps program serves a population of families that is representative of the diversity of American families. Sites will consecutively enroll all newborns entering the practice. The total number of children to be involved in the intervention will be approximately 3,000 and another 3,000 will serve as controls.

Comparison groups and control sites: The evaluation design anticipates two kinds of comparison strategies. In 6 of the 15 Healthy Steps sites, families will be randomly assigned into intervention and control groups. At the remaining 9 sites, a comparison location has been selected. At these sites, the populations will be compared using a quasiexperimental, pretest-posttest nonequivalent control group design.

■ Early Evaluation Results From the First Year of the Healthy Steps Initiative

Margaret Caughy, Donna Strobino, Mary Benedict, Nancy Hughart, Janice Genevro

The first year of the evaluation of the Healthy Steps initiative included completion of the formative evaluation at the Allentown site as well as the completion of baseline data collection for the outcome and process evaluations. This paper summarizes results from these components of the evaluation.

The formative evaluation of the Healthy Steps program was conducted during the first months of implementation at the pilot site. The evaluation design for the Allentown site is a randomized trial, with a total of 400 families being randomly assigned to either the Healthy Steps program or the control group. Data sources for the formative evaluation include data from the process monitoring system, interviews with participating families, surveys of clinic staff, key informant interviews with select personnel, and focus groups with families and staff.

The multimethod approach used by the Healthy Steps program was an effective approach to formative evaluation. The quantitative data sources provided a snapshot of the enrollment experience, the characteristics of families, and the characteristics of the clinical staff at the pilot site. The information about the enrollment experience of the pilot site during the formative period confirmed to program staff that the projected enrollment rates were reasonable and did

not need to be adjusted. Although the quantitative data collected as part of the formative evaluation was useful, it was the qualitative data from focus groups and key informant interviews that provided the richest picture of the experiences of the pilot site while implementing Healthy Steps. Focus group data indicated that families as well as providers perceived the services provided by Healthy Steps as a valuable addition to the pediatric practice. In addition, families enrolled in Healthy Steps during the formative evaluation period reported being very satisfied with the services received.

Although the program was positively received, there were also indications that the implementation of the program was formidable. Key informants consistently reported that the implementation of the Healthy Steps program required significant planning time and affected the entire practice. Based on the results of the formative evaluation, the training program was expanded, technical assistance calls were implemented, and an introductory video was distributed.

Baseline data for the outcome evaluation includes family information collected during the newborn period, telephone surveys of parents at 2-3 months postpartum, and surveys of clinical staff. To date, a total of 4,965 newborn surveys have been completed on participating and comparison families. Data on the demographic characteristics of families indicate that participating families represent a broad cross section of families with young children. Because of the staggered implementation of the sites, complete data are only available from the surveys of clinical staff. A total of 479 surveys of physicians, nurses, and administrative staff were completed within a few months of program implementation. Results of preliminary analyses of these data indicate that the Healthy Steps program is addressing a gap in the service delivery of pediatric practices across the country.

Language Development and School Readiness

Early Literacy Conversation Hour With Barry Zuckerman*

*Abigail Jewkes substituting for Mr. Zuckerman

Abby Jewkes: Unfortunately, Barry Zuckerman was unable to come at the last minute, so I have come in his place. I work with him at Boston Medical Center in the Department of Pediatrics. Specifically, I work in our Reach Out and Read program, which addresses early literacy in the context of pediatric well-child care. I will be talking about that model and about the program. However, the focus of our time is a discussion of early literacy. I would like to start out thinking about the different aspects of language and literacy and all the influences that affect language and literacy.

All children, especially those at risk, should have access to environments that promote language and literacy from an early age. In thinking about what the predictors of reading success and failure are, I want you to keep this model in mind of three different areas that influence reading success. Picture it as concentric circles. The middle circle and the starting point would be any abilities that are intrinsic to the individual. One starts there with the actual child and with any skills and abilities that have been ascertained through any variety of child assessment techniques.

The next level would be family and home environment, since in the early years of life that is where children spend the majority of their time. At another level, one should determine how the community and the schools and any other environmental factors outside of the children's family influence literacy development. All these different levels should be thought of individually, but they also are interchangeable and influence one another. It is very dynamic.

Despite support at the federal, state, and local levels for early childhood education, especially for those living in poverty, there is not really a focus on literacy. There may be pieces, but it is not explicit at any of these levels. That is what we need to be thinking about in terms of the next steps to take.

In addition, we need to think about the cultural aspects of literacy, such as the influence of the family environment and also the larger environment to which the child is then introduced. Literacy is innately cultural. Researchers have looked at different families and cultures and have viewed literacy in different ways. For example, in her book, "Ways With Words," Brice-Heath studied three different cultures in one community. The three cultures saw literacy as having different purposes and functions, which clearly influenced the actions that families took regarding literacy.

I am going to talk about children from lower income levels and the consequences for their literacy levels. It is important to note, however, that opportunities for literacy do exist in lower-income homes. The issue is that their literacy practices vary from the mainstream middle class, and that is often what formal instruction has been based upon. As such, low-income children often have difficulties because the literacy that they are exposed to as young children in their

home does not match with what is going on in the school system. That makes that transition extremely difficult.

Other conditions for children's reading success, such as the child's intellectual and sensory capacities, vary a great deal between individuals. In a moment, I will talk more about brain development and its influence on children's literacy development.

Children have positive expectations and experiences with literacy starting from a very young age, as early as infancy. Thus, literacy needs to start as soon as a child is developmentally ready, and they are ready as young as infancy.

Another factor is support for literacy activities. Having literacy activities is not enough. There also needs to be a supportive environment. If a child is in some sort of program prior to entering formal schooling, literacy needs to be addressed. Literacy needs to be reinforced in the child's environments, particularly the home and family environment.

Phonemic awareness is another factor. Children must have the basic knowledge that sounds are distinct from meaning. They may not understand this at that age, if they have not had enough experience with text, print, and language. That is one of the first steps in this literacy development.

Children also need knowledge of letters to begin learning to read. That can start occurring at a very young age. What about low-SES children? In general, children who have difficulties learning to read, especially those in the primary grades, begin school with less prior knowledge and skills in the relevant areas. They do not have general verbal abilities. There has been a lot of research looking at the language of children and what kind of skills they have when they start school. A lack of those skills is a good indicator of later problems with reading.

Who are we describing when we say at-risk children? They are frequently Latino and African American children. They have limited English proficiency. They are from poor, urban neighborhoods. They have hearing and/or language impairments. They also have parents who have had difficulty learning to read themselves. One cannot underestimate looking at the parents to see what their experiences have been throughout their life with reading. If parents did not have positive experiences with literacy and reading was not an enjoyable activity or was not nurtured, they will not know how to do that for their children. If parents are uncomfortable with their own literacy abilities, which may not be much better than their young children's, how does one overcome that barrier so that parents feel comfortable working with their children?

Low-SES families tend to live in communities where the average family income is low. Living in this community, they frequently receive less adequate nutrition and health services, including prenatal and pediatric care, the ramifications of which are obvious. If children do not have the services they need for basic human biological development, it will impact every area of their development. Literacy development is obviously a piece of the broader area of child development.

Low-SES children may very well enter school with some initial reading skills, but the time outside of school, prior to school, and during summer months is critical. This is when gaps are created. Even if children start at the same point, if they do not have the additional experiences that children from other economic backgrounds may have, this causes a gap that, even over time, cannot be closed. Consistently, when children are studied longitudinally in school, those with reading difficulties do not catch up, because time outside of school is not being addressed. They may be making progress, but the gap between them and their counterparts who are doing better is not closing.

This may speak to what is going on in our educational system—the educational equality and potential biases in the development of curricula for a White mainstream population, which does not serve these other children who are at risk for all these different reasons.

Interestingly, schools with large numbers of urban minority students may send as many as half of their students into second grade unable to read in a conventional sense. Research shows that by second grade, children should be able to read independently. It is astounding that half of

the children in urban minority school districts are not entering second grade with an ability to read. Such children are not going to be able to make that up, no matter what kind of exceptional teachers, programs, or practices may exist.

I would like to talk more generally about literacy. Again, try and keep in mind all these different aspects, specifically the culture of literacy and children from lower-income backgrounds—the different issues they face and the obstacles they must overcome. Early literacy is an essential part of child development, but what do we mean when we say literacy? I am going to pose some questions in order to frame literacy in this fashion for the purpose of our conversation.

Do you all remember being read to as a child? Maybe at bedtime, while sitting on a parent's lap in a rocking chair? Did you have a favorite child's book that you would read over and over again? Was obtaining your library card a rite of passage? Were trips to the local library expected and exciting adventures? Was your home filled with books and other reading material? Do you remember seeing your parents reading for pleasure? Did you view reading books as fun and enjoyable?

I will never forget when I was learning to read as a child. One of my favorite books to read with my mother was *Mr. Pine's Purple House*. Even though I could not read the text, I knew that at certain points when she was reading to me I should fill in the end of a sentence with "Mr. Pine's purple house." To this day, my mother reminds me that I would scream it at the top of my lungs because I was so excited.

That is an important step in this developmental process of literacy—helping children recognize that what a reader is saying is being read, and that print carries a message, that the reader is not just making up a story or telling a story. Print means something. Then, as time goes on, because of their natural curiosity, they want to know what that is. They realize that one is not just memorizing the book but that one is actually reading it.

Question: What if my answer had been no to all your questions? No, I do not remember ever having been read to by my mother. No, I do not remember a book environment in the house. For every single question you asked, what if the answer were no?

Jewkes: That is a real issue for many families with whom we work. What we need to do is give concrete advice and models for parents.

Comment: Both my parents are highly educated and middle-class, and they happen to be Latino. I want to make sure that people realize that there are many cultures that do not initiate reading practices until the children enter school; it is not associated with just low-SES families. It also can be associated with other families where reading regularly is not a pattern.

Jewkes: Definitely. Thank you for reiterating that. That is why I think the issue of the culture of literacy is so important. The only reason I am focusing on low-SES children is because that is where my experience lies.

Often, some of the criticism we get about the Reach Out and Read program is that we only target low-income children. What about upper-class, well-educated parents who do not have the time to spend with their child or are not doing any kinds of developmental activities with them? That is another issue. It really can be overwhelming if one looks at all the different factors that are involved.

Additionally, the issue of culture arises. There are certainly a great number of cultures that are very literate, but maybe not in terms of written word. Perhaps the oral tradition is what they know. One needs to understand that people have different experiences and to build on that. Most people have some level of literacy. One needs to get at what that is, and then build on that when one is working with parents. Whatever the parents know is what they will pass on to their children.

You jumped to my point. After reading these questions, I was going to stop and think about how life could have been different if I had not had these experiences. Think about, as adults, if reading is an important part of your life. Do you read for pleasure?

Comment: Because my answer was no to your questions does not mean that I did not acquire all of the necessary literacy skills at a certain point. I do read for pleasure. Rather than thinking of it as a lack of something or a deficit to be made up, I see it as a delay until a certain point of time when everything started.

Jewkes: Yes, that is very important, and even though the evidence can be negative at times, one should not look at anything as a deficit model. One needs to look at what the children bring with them. What are their experiences? They may be different from other children, and that is where these issues and problems really occur. How do you work with this pool of people with a variety of experiences at varying levels and with various purposes and knowledge?

Comment: I am from an area in southern California that is becoming increasingly a technological center of computer development. We have started exposing young children to computer technology. Rather than seeing the printed text on a page, they first begin to see print on a computer screen. Do you want to comment on that?

Jewkes: I do not have a lot of expertise in that particular area. It is such a new area that there is not a lot of research on it. It will be interesting in another 10 years to see what happens as schools move into computer-based learning. If you are giving children some kind of format and tools to engage in any literacy promoting activities, and they are comfortable with it, then that is what is important. It depends on what type of activities they are given to do on the computer. There are many different kinds of learn-to-read software. I do not know if they are necessarily as valuable as text because they are constructed and more limiting. They are preprogrammed to operate a certain way. If there is a computer reading a child a story, it does not engage the child by asking questions and allowing them to have a conversation, which is an extremely important part of literacy development. Literacy development is not just sitting there looking at the pictures. It is dialogic reading, an engaging process that stimulates children's interest and cognitive and language development.

Comment: I have not heard anyone mention examining the various definitions of literacy. I work for an organization called Very Special Arts where I manage an early childhood program with a literacy component. It is designed to inherently motivate excitement about being involved in art activities so that the children will become more literate in their communication skills. This leads them to understand that pictures, even those they create themselves, have meaning. Understanding that other people can read and understand what they create has great meaning to children.

We should not forget that there are many ways to define literacy and to provide children with the opportunity to become successful. I recently met two individuals, one is 40 years old and the other is 60. Neither has ever learned to read; yet as visual artists, they are highly successful verbal communicators. One has work in the New York Metropolitan Museum of Art. If we say there is only one way to become successful, a huge portion of our society is left out.

Comment: Referring to what was just said about technology, today's children have been raised in a visual world. They watch videos and TV much more than my generation did. They perceive information, and they communicate information in pictures.

Jewkes: That is a great lead-in to my next point. I want to talk about what we mean by literacy. Biological, psychological, and social forces influence literacy, which is directly linked to school success and life outcomes. When one's literacy skills are poor, one sets oneself up for school failure, which could lead to dropping out, low self-esteem, substance abuse, and teen pregnancy. I know it seems like a big leap, but there are statistics that support my point.

There is a great new book that I would encourage people to read, *Preventing Reading Difficulties in Young Children.* It is a product of the National Research Council, but it was put together by a panel of experts throughout the country who had been collecting information about what factors are involved in reading success and failure for at least 2 years. They explored the period prior to the school years—what needs to go on, programs that work—and then explored what goes on once children reach school age.

This book examines early literacy development through the latest research. The authors found that academic success, which they define by high school graduation, can be predicted by a child's reading skills at the end of the third grade. That is such a powerful statistic when one thinks about how many years there are between third and twelfth grade. One would think that if a child has difficulty reading, 8 or 9 years would give them time to overcome it. Part of the issue is that in third grade there is an interesting transition in school. From kindergarten to third grade, children are learning to read. After that, they have to know how to read in order to learn all the different subjects they are taught. So it is a critical juncture. A lot of educational research has shown that children can be doing well up until that point, and then there is a big drop from fourth grade on. For a while they could not figure out why this was. Then they started looking at how children were taught to read and how school curricula are based on that notion.

Here are some factors that affect what happens early in children's lives. Thirty-five percent of first graders are placed in remedial reading programs. Even though only a small percentage have some form of dyslexia, they often remain in this track system throughout school. From the beginning, they are identified as having some kind of issue with reading or learning, which may not always have been assessed accurately. This puts them on a path that limits their overall school success.

The following data are the reading performance levels of fourth graders in Boston public schools from May 1996 to May 1997. They looked at a 1-year period because one would think that children's reading skills would improve during that time. Fifty-eight percent of these children remained at the same level. Only 13% improved, and 29% declined. Similar results would probably be found in other large urban school systems throughout the country.

Question: Is there any documentation as to whether the 35% of first graders you mentioned, were placed in remedial programs for valid reasons as opposed to assessment errors?

Jewkes: Only 4-10% of these children should really be in any kind of remedial programming. That is the bigger issue. Reading performance is not being assessed properly.

Question: Is that saying that only children who are dyslexic should be placed legitimately in a remedial reading program?

Jewkes: No, but that is often how placement is assessed. The issue is that dyslexia is not the only reading disability, but it is often what is diagnosed.

In a 1996 report, the National Assessment of Educational Progress found that 40% of fourth graders are reading below their grade level. When one looks at the different ethnicities, 69% of African American children fell into this category. That translates into 4.5 million children in this country. For Latino children, 64% were not reading at that grade level, which translates into 3.3 million children. There are many fourth grade children who are not reading well. Based on research, they will not catch up and will not be prepared when they get out of school. They are

being set up for lifelong problems.

Now we are going to look more at the issue of adult literacy. A 1990 report found that 68% of those arrested, 85% of single mothers, 79% of welfare dependents, and 85% of school dropouts were functionally illiterate. There are many different measures that assess literacy, which is why one will hear all different types of statistics and facts about how many functionally illiterate adults there are in this country.

I want to look now at two national studies done on adult literacy to give you a better sense of the issue. The Educational Testing Service (ETS) conducted a study in 1992 to assess adult literacy nationwide. Twenty-seven thousand individuals age 16 and over were asked to complete a variety of tasks and asked if they had received AFDC or food stamps in the past year. The results showed that adults who had received AFDC or food stamps had more limited literacy skills than other individuals in this large study. More than one third performed at the lowest of five levels, which means they were able to follow instructions and fill out a very basic form. This is the most difficult task they could complete.

Comment: I live in Appalachian Virginia, where we have to take into consideration a number of factors, such as cultural expectations and dialect differences. Growing up in Appalachia, reading is not important. The application example at level one is not important to this Appalachian community. We are working with relatively agricultural families, where an application for employment means going to the feed store and talking to the guy in there and saying, hire me. I work in the Head Start program, and we look at these factors when we work with families. We look at cultural influences and what is expected of us in our culture. When one asks lower socioeconomic families to move into the middle class, essentially one is asking them to discard some of their beliefs or family values and expecting them to become something else.

Jewkes: Yes. I agree with you completely. I think it really speaks to the issue of assessment and how it is done. One should ask whether it is an appropriate assessment for the people who need to be reached.

The book I mentioned before pointed to the issue of culture in the literacy world. Brice-Heath's work was done in Appalachia. I understand exactly where you are coming from and it cannot be stressed enough because the awareness is not on a large-enough level for a national study. If the type of literacy task used for assessment is not appropriate or relevant to someone's life, the usefulness of the data can be undermined.

Comment: You mentioned African American children, who have differences in dialect. From my years of experience working with Head Start children and speech and language pathologists, I found that these children would be singled out because they do not say the word as the pathologist would—they say "ax" instead of "ask." Speech and language pathologists cannot determine their language skills properly because they cannot, in my experience, understand the syntax of the child's sentence. If we are looking at early literacy or emerging literacy skills, we need to look carefully at how to help children retain those family values and an appreciation for where they come from while helping them gain literacy skills that they need to be successful.

Jewkes: Exactly. There is still a tremendous debate about dialect. Some people argue that everyone should speak standard English in this country and deny that African American English vernacular is indeed a language. According to the principles that are internationally known throughout this country, there are standards for what constitutes a language and it fits those guidelines. There are rules and patterns, if one goes in and explicitly looks at them. I think it is an issue that some people are aware of, but not everyone is.

There is still debate because the idea of early literacy is still a relatively new field. There has not been enough time to do a tremendous amount of research. As such, a lot of the research is

very general or has not been going on long enough to show anything. I cannot agree with you more. It is so important to keep in mind where the children and families you serve are coming from and what their experiences are and to value those experiences, even if they are different from what you may know or what your own practices may be.

Question: If 35% of first grade students are being placed in remedial programs but only 4–10% are accurately placed, how are they actually being assessed? My other question is based on these different dialects. What are the implications for future success, for example, after third grade?

Jewkes: I do not know how they are being assessed. The point is that this is setting these children on a remedial path that will doom them. They have been labeled and been told, "You are slow, so you are in the remedial program." Children pick up labels, and they then believe that is what they are. It is an issue of expectations. When children hear this enough and when there is no one from outside the school, family, or community environment connecting with them and telling them that even though this has been said, "I am going to work with you and mentor you," this has an impact.

There has been research conducted on children who fall into all these at-risk categories and who have succeeded. Harvard has been doing a great study, entitled "Unfilled Expectations," on children who were highly at risk but who were doing very well. One of the points that stands out is that the children said they had someone, whether it was a parent, another relative, a family friend, a teacher, or a mentor, who worked with them and gave them support and nurturance. They were just as academically successful as the most traditionally successful students were.

Going back to the ETS study, at level two there is an example task, which requires the respondent to read instructions. There is a broken clock, and the instructions describe what to do if there is a problem. The respondent has to read the instructions and then pick the statement that best states which course of action should be taken based on the reading. The interesting fact is that two thirds of adults fell into either level one or two, which means that for two thirds of these 27,000 adults this was the most difficult task that they could complete. That does not speak very well of their abilities.

Comment: I disagree with much of what is being said. I think that what we are talking about is not denying someone's culture or family background, which I think everybody in this room knows to be very important. The culture of poverty, however, is not a value. In order to get beyond the culture of poverty, one has to know how to read, to talk, and to draw. One is not going to make it through high school if he or she cannot read. In Head Start, if we do not see that as an extremely important goal for every one of our children, regardless of where they come from, then we are missing the boat for our children.

Comment: Additionally, it seems as though some of the arguments I am hearing confuse an evaluation of intelligence versus an evaluation of literacy. If one places value on a narrow definition of literacy, then one is saying that they are not intelligent or capable, because according to the standards they are not able to do this. However, they may be able to do it in other ways.

Jewkes: Yes. When we asked graduate students to complete the level five task, there were many students at a top-notch university who could not do a simple task such as reading a bus schedule. There are certain things that are not presented well, and if I were to be tested, maybe I would fall into one of these lower categories. So, I agree that the way someone is tested is important. Again, the focus is on the written aspect of literacy, and literacy is not just about the written word. It is reading, writing, listening, talking, and communicating. For a long time,

people thought of literacy as only reading and writing, but today it is viewed in a much broader sense within the literacy world.

A few people pointed out that just because an individual could not answer questions correctly on this test does not mean that they could not in another context. Indeed, there are many adults who cannot do this, but they develop systems and learn how to function successfully in life even if they have low literacy levels.

Comment: That was my point. Let us start with the idea that everybody has skills and abilities that should be nurtured and reinforced. I am not saying that people should not learn to read. Certainly they should learn to communicate to the best of their ability. Our organization works with people with disabilities. If they cannot complete a certain task, that does not mean that they will not make it in the world.

Jewkes: In addition, the statistics that come from a study like this are published. So one reads in the newspaper or hears on the news that 40 million adults are illiterate in this country. What does that mean? It could mean a lot of different things depending on who was sampled. Did they sample a people in an urban community? Was it a representative sample?

People want to receive information quickly. They do not want to take the time to look at all these factors. It is extremely complex and teasing out each aspect is very difficult. We have just started to be able to do that.

Comment: This is regarding what was said about the process of a child learning to read. Just because a child in the third grade still has to sound out every word she reads does not mean that by the time she reaches the fifth grade she will not be reading just fine. We should not put children who are struggling to read on a pre-determined, standardized level into remedial classes. These classes destroy self-esteem. Teachers completely forget that children sometimes have vocabularies that rival most adults. They can do math problems in their head that one could not do with a pencil. Literacy is important, but we run into the danger of making it so important that we disregard other cognitive abilities.

Jewkes: Oftentimes, if one is not working with children directly, one underestimates their abilities. If one works with them on a daily basis, one realizes their potential and curiosity and that they are ripe for learning and absorbing information. The issue is how to tap into that, because it varies according to individual differences. How do you address a classroom of children from different backgrounds with different experiences and interests and different ways of learning? It can be very tricky. There are adults who were in a school system where they were tracked by teachers who thought negatively about them. It was overall a very negative experience for them, and they have carried this with them throughout their lives because it is all they know.

In this study, we looked at the income levels and literacy levels of participants. As expected, as their income level increased so did their literacy level. Those who were receiving public assistance did not have much income variability, because the government dictates how much income they receive. That is a real factor when one looks at poverty. Without economic opportunity, opportunities for education and literacy are limited and that has numerous ramifications on life outcomes.

The National Adult Literacy Study, which is quoted frequently, found that 90 million adults in the U.S., or 40% of the adult population, function at the lowest two levels of literacy. It also found that the U.S. ranked 49th out of 159 countries in adult literacy levels. It is rather sad that our literacy levels are so low in comparison to other countries, since supposedly we are one of the most advanced and developed countries in the world. Even though 40% of adults were in these lowest two levels, most people reported that they read well or very well. That speaks to many of the issues people have been raising today. People do not necessarily think that their

literacy skills are poor if they are functioning fine in life. One has to keep that in mind.

The study also assessed a smaller group of 369 parents from a pediatric clinic using the Rapid Estimate of Adult Literacy in Medicine. This instrument is geared towards measuring adults' ability to identify and understand medical terminology, from basic terms such as aspirin, blood pressure, and temperature, to very technical medicalese that may be unfamiliar. They found that the mean reading level of these parents was at a seventh- to eighth-grade level.

Keep those results in mind when hearing about this next study in which 129 medical pamphlets distributed in physicians' offices were tested. It was found that 80% of the pamphlets were at the ninth-grade reading level or higher. If the mean average of the targeted population is at a seventh- to eighth-grade level, they obviously will not be able to fully comprehend that information.

In another set of handouts from the American Academy of Pediatrics, 25% were written at below ninth-grade level, and only 2% were below a seventh-grade level. There is a lot of research about health and literacy, specifically about important information provided by health care providers, such as how to medicate your child or yourself or instructions after any kind of surgery or treatment. Researchers have found that this information is often written at a level that is above the patients' and families' literacy level, which affects health outcomes. If they cannot understand the information describing how they should care for themselves, they will not get better, and this will have direct implications for their future health development.

I would now like to address the history of literacy acquisition theories. In the 1920s, it was believed that reading could be only taught at a specific age when the brain was prepared. This was known as neural ripening. One parent from that time said:

> I completely discouraged my first child from reading before he was taught in school. My second child learned to read while in kindergarten, but the teacher informed me not to encourage it. Now my 4-year-old son has started reading, how he learned I am not quite sure. One morning he was sitting and reading different words. I took the book later and sort of hid it.

Another parent said: "When my daughter asked about words, I just told her she would learn to read when she got to first grade. I did not want to teach her anything that might cause problems later on."

In the 1960s, there was the idea of reading readiness, which purports that learning is a set of sequence events with basic skills, such as letter sounds, preceding mastery of reading. Instruction is formal and direct. Phonics evolved from this theory, and this is probably the way a lot of us were taught to read. This theory certainly should not be devalued. Some of these skills need to be utilized and integrated in any kind of reading instruction.

Then, in the 1980s, the idea of emergent literacy returned. This is the belief that literacy development begins before formal instruction; listening, speaking, reading, and writing develop simultaneously in real-life settings. This has influenced not only the literacy world, but also the educational world immensely, and continues to emerge since it is still a relatively recent field. Prior to this, literacy was simply viewed as reading and writing. Language was separate and was seen as talking and understanding.

Emergent literacy theory views language as expressive—communication through speaking and writing—as well as receptive—processing information that is read or spoken. Language can also be viewed verbally and visually, which have similar paths of development beginning with this idea of shared attention. A child has to look at text or pictures or pay attention to whoever is speaking.

The child's first attempts at each of these are babbling with verbal language and scribbling with visual language. Then the child starts to put words and sounds together to form telegraphic speech such as "want book, give bear." Even prior to that, children certainly have nonverbal ways of communicating what they want. Young children will point or scream, and you will be

running around like crazy trying to figure out what they want. This is all part of literacy development. Eventually children can have conversations and also produce written word.

The educator, Judith Schickedanz has identified skills associated with books and reading. This includes the idea of book-handling skills, such as children being able to turn the pages, getting a book right-side up, giving a book to an adult as a way of telling them they want to be read to, and understanding when pictures are upside down. There is a progression, which works off the idea that there are skills in literacy development, as in the cognitive and physical development of a child, that should be reached at certain ages.

In addition to book-handling skills, children acquire picture-reading skills, such as pointing if they are asked to identify something. They also learn to ask what something is and, eventually, when they understand a story, to ask, "Why did that happen?" That is understanding on a much broader level.

The most amusing of a child's sets of skills are story-reading skills. Infants will take a book and look at it. It may be upside down or right-side up, but they will babble in a real cadence that one hears when people read stories. They say, "Ba-ba-da-ba-da-ba-da." I have seen it with children with whom I have worked. That is a sign that they have had exposure and are beginning to make the connection that they are looking at a book and that there are sounds associated with it. They will also start to fill in the words at the end of the text. That can happen as early as 15 months if a child is being read to. They will also read to animals and dolls.

What happens if one is reading a book late at night to a child, and one is tired and just wants to finish the book and put the child to bed? Perhaps one skips a page. The child will let you know you skipped a page and make you read it.

Children will also start to read familiar books to themselves. There are children even as young as 2½ who, if they have been read a story over and over again, will sit and say the text. They have no reading ability; they have memorized it. They think that whoever has read the book to them has memorized it; they do not realize that the book is being read. This is another important step in literacy development.

There are a series of tasks known as the roots of literacy, which also set the stage for reading and writing. One of these is awareness of print in a situational context: using print as cues, such as reading a McDonald's sign or a stop sign.

We are conducting a study at Boston Medical Center to assess the literacy abilities of children ages 5–6. We found that there are no emergent literacy assessments for children younger than age 5, partly because there is such variability and this is such a new field that no assessments have been developed. There is one called "Concepts About Print," developed by Marie Clay in the 1970s, that has been normalized on children of all different backgrounds throughout the world. It was developed in New Zealand and has also been used in other languages. It uses a storybook format.

We work with many minorities and under- or uninsured families, who may not have the money to purchase books and, therefore, may not have books in their homes. We thought that a traditional storybook format assessment might not be valid. So, we developed an alternative measure using a cereal box, based on the idea of environmental print. All the different items from the traditional assessment were matched on the cereal box. "Fat-free" is on the box, and the "a" and "t" are reversed. That is one of the items about which the participants are asked. It ranges from very basic items, such as whether the child can get the box right-side up, to identifying words out of sequence in a phrase or a sentence. We are assessing children with both of these measures—a traditional one and an alternative one—and comparing their scores.

Preliminary results have shown that these children are scoring better on the alternative measure—the cereal box. Initially, it was a small pilot group of children, but now we are trying to expand it. This speaks to the issue of assessment. Just as we were talking about assessment in terms of adults, we need to look at the children and what their experiences have been. If "Concepts About Print" is the only standardized and validated assessment for young children,

and it is used at ages 5 to 6 when these children are entering school, then our findings can speak to the issue of misdiagnosis of reading disability.

From the assessments that we have done, these children generally score very low. Even if they are in kindergarten or first grade, they score anywhere from 0 to 5 on a scale of 20. The mean should be at least 15 for a 5- or 6-year-old.

Question: Do you think the cereal box was a better assessment? If yes, why?

Jewkes: It is better for this particular group of children. We are targeting low-income, urban, minority children. They perform better on this assessment because that is what their literacy experiences have been. They do not always have books. So, when they are tested using a book, they do not understand what it is. However, a cereal box is something they have and see every-day in their homes.

Comment: If one could assess reading ability with the cereal box as compared to the test, one would have a very different perspective of the knowledge base that the child has and what should come next. It seems that some of these assessments forced the interventionist to carry out a certain kind of activity under the assumption that the child did not have any skills.

Jewkes: It gives you a better picture of what this child is bringing to whatever setting in which one is working with him or her. One can then develop something that is tailored to existing skills and knowledge and that will lead to greater success.

Providers of all sorts and educators say that on their first day with a group of children they can tell who has been read to and who has not, just by telling them a story. Children realize that a story has a beginning, middle, and end, which is the idea of understanding sequencing. This understanding translates into whether a child can follow directions. Does the child understand that first this needs to be done, and that needs to be done second?

There are forms and functions of writing, beginning with scribbles that resemble drawings. The next step is understanding that writing is different from drawing. Young children think they are one and the same; they do not see them as separate things.

A classic example is children's scribbling on a page from left to right and top to bottom. Maybe it resembles letters, but that is not what it is about. Children have observed other people write like this. If one asks them what it says, they will read it and tell you the whole story about what they did yesterday. They recognize writing as symbols and realize that what they say can be represented in another way.

The next stage is children having the ability to: (a) be able to talk about language, (b) label, (c) identify letters and numbers, and (d) understand that words are associated with language and be able to say, for example, "read, write, draw, book, and story."

On a more complex level, metacognitive and metalinguistic awareness occurs, which is an understanding that words start with the same letter or have rhyming patterns. Toddlers will go into hysterics if one reads them a story that is full of rhymes. When they have some language ability and understand that they can do this themselves with their friends, they find it amusing and can entertain themselves for a long time. This awareness can be demonstrated as early as age 3, if children have had rhyming experiences. Even though it may begin at that age, it continues throughout school.

Educational research has documented the benefits of literacy-related activities on reading and school success. One of the most compelling findings is that the single most important activity for building the knowledge required for children's eventual success in reading is reading aloud to them. This is especially true during the preschool years, and this is the basis for many interventions and programs prior to school. It is really a new idea that came from the National Commission on Reading approximately 10 years ago. The message has been translated into

action. The Seventh Annual Report of the National Education Goals Panel found that an increasing number of parents regularly read to or tell stories to their 3- to 5-year-old children. In 1993, 66% of parents reported this, and 3 years later, it was up to 72%. This certainly could be higher, but at least there is a positive trend.

Question: What would you say accounts for that increase?

Jewkes: There is more awareness of literacy in the greater community. Not only people involved in education have been trying to communicate to the communities that literacy work is important. It is slowly starting to catch on, and it is being voiced to parents. People realize this, not only on a professional level. They are using this knowledge in their work with children and that message is reaching the parents.

Question: Is there a comparison between parents who read books to their children and a literacy-rich environment that does not necessarily involve reading?

Jewkes: I think there has been, although I do not know of anything offhand. It is actual book sharing that has been proven to be essential. It is essential because of the way instruction is constructed in the school system, which is based on the idea that when one goes to school, one sits, reads, answers questions, and responds. The engagement that should occur with reading is what is done in schools. I do not necessarily think that literacy activities that do not revolve around books are not important. Certainly they are. The issue is that there is a mismatch when the children reach school.

I am not sure if there are studies that compare or contrast. However, there may be because I know there is research that says book-reading, in particular, and book-sharing in early years are important.

The type of relationship, involvement, and views the parent brings to their role in child development is also important. Parents may think they need to help their children only up to a certain point and then the school should take over.

Comment: There has been an increasing number of studies that look at early literacy and the social process and how that affects social competency in children, which, in turn, will affect their academic success and relations. Learning these social processes in school is critical, as the more competent children are in those relationships, the more they gain in their education.

A study examining parent relationships found that a higher quality parent/child relationship led to better literacy skills. Researchers specifically looked at parents reading picture books to their children and the differences in their reading patterns. They picked out specific patterns in these parent/child relationships that showed a link between social competency and literacy.

It is important to look at the quality of the parent relationship. Is it just book reading that enhances these early literacy and social competency skills or is it the quality of the parent/child relationship across the board in all of the different activities in which they engage daily?

Comment: As children get older, I think it is important to continue to read to them. When they move on to more skills, it is sometimes nice for children to be able to sit back and let somebody read to them.

Jewkes: That is an important point. As children get older, they must read for comprehension. If they have had some difficulties, it is crucial to have that assistance, someone to work with them, read to them, and go through it together. A reader could discuss with a child what the character was thinking and feeling, what the main idea was and what happened. This activity needs to continue all the way through childhood.

Comment: Whether it is a child or a friend or a parent, the social process can also help children, either by motivating them to read more on their own or to give them positive feelings or memories.

Jewkes: That is a key point on a broader issue that touches upon the relationship between parents and children. When working with literacy, we do not underestimate this relationship and we remind people, especially if one encounters families that have difficult relationships between the parent and the child, that reading and looking at books can be enjoyable. If one is working with a difficult child, this can be an enjoyable time to share and build up relationships.

Comment: When adults read to children, they should be sure that they track the words with their hand. That is how the child makes the association between what that person is saying and the words that they are reading.

Jewkes: I agree. There are basic things about reading and looking at books that one needs to think about when working with families. It is okay if you have an infant and he or she takes the book and sticks it in his or her mouth. It is constructive for them to do that. Another basic idea is asking questions and modeling for children when working with them, such as saying, "Look at the pig, what is the pig doing? The pig goes oink, oink." Also, it is good to remind parents that they probably already know what to do. Those are basic things that you have done with your own children, that you remember, and that you do in your work. Those are the kinds of things that we need to pass on to parents. It is not complex. In fact, it is very simple. Oftentimes people get caught up in complex issues, but what it boils down to is very basic. If they do not know what to do, if they do not have that instinct, then you can recommend basic practices.

Positive reinforcement is key. If a parent sees that the infant looks at a picture and his or her eyes light up or if the infant starts patting the book or putting it in his or her mouth, that is a good sign because it means the infant is interested. Parents may be dismayed about this and think that their infant is too young. Since he or she cannot even talk, how will he or she understand if I read a story? Remind parents that it is not difficult and model it for them to give them some examples of what to do.

Comment: Most of the parents with whom I work have limited literacy. They have not had reading experience. I cannot simply say to them, "Read to your children." I have to train them how to read to their children.

Jewkes: We have specific advice for parents with low literacy abilities. There are things that you can suggest to them. Do not worry about the text. If there are stories with pictures, the parents could just look at the pictures and point out things, such as "Look at the baby. She is playing with the blocks. Let's count the blocks. One, two, three, four, five, six." One needs to be very explicit, however. One cannot simply tell parents to take a book and then read it with their child.

Question: Are programs being developed through Head Start to work with parents to give them adaptations that they can use in reading to their children?

Jewkes: There are some. I have very limited knowledge about Head Start. Reach Out and Read addresses this very explicitly.

Comment: We are very interested in the America Reads channel. We have summer college students out in many communities working with children and with parents to promote literacy.

Comment: We have a literacy program, and our staff has spent a tremendous amount of time trying to find books that are culturally appropriate for the program participants.

Jewkes: It is very important that the literature that one chooses is appropriate for the populations with whom one is working. In our work, that is key. The publishers are definitely responding to that, and there is certainly literature for all different populations. There is literature about culture and children from Latin America and the Caribbean. There are bilingual books. We work with some publishers who have just devised a book that is bilingual—English and 10 other languages—that we offer to our sites. The languages include Spanish, Portuguese, Vietnamese, Chinese, and Haitian Creole. We looked at what languages the participants in our sites speak. There have certainly been more books in English and Spanish, but apart from that, there are not very many books in other languages.

I want to say something about brain development. The emphasis on the first 3 years of life, with the first year as the most critical, fits in well with this idea of early literacy. One needs to think about the fact that neural systems in children are plastic. They respond to altered input. When children are read to or there is any kind of stimulation of their brain, the number of synapses between the neurons is increased. These connections are critical to children's health and development. Remember that this development occurs at irregular rates. There may be times when suddenly one feels as if children have made incredible gains in a very short amount of time, and then they go for a period of time where it does not seem like they are absorbing as much information. One also needs to take children's individual differences in the biological and physiological makeup of their neurological systems into consideration as well as the experience that they have had.

Question: I would like to briefly tell you about Reach Out and Read. It is a pediatric intervention that broadens the definition of well-child care. Reach Out and Read is a way for pediatricians to go beyond traditional pediatric care to help the whole child and the family, and it acknowledges the importance of literacy. First it started out including safety injury prevention, behavioral pediatrics, language development, and functioning in school. We are hoping that literacy will become another standard part of pediatric care.

Why pediatric care and why work through pediatricians and nurse practitioners? The answer is because they have very early contact with parents. There is no one else who sees parents consistently one-on-one that early in a child's life aside from the physician. This assumes that the parents are going regularly to all their scheduled visits.

Our 5-year goal is that pediatricians who promote literacy and give out books will be as common as those who give immunizations. Both are important for children's health and well-being.

The Reach Out and Read program has three components. First, doctors give advice to parents on how to share books with children. We train doctors so they have that information. The second component is giving children books to take home, starting at their 6-month visit and every visit up until age 5. That is a total of 10 books from the time the child starts kindergarten, because there are about 10 standard required visits and each one comes with age-appropriate advice and guidance. The third component is having volunteer readers in the waiting room to model reading behavior to the parents.

This program has come along at a time when we are beginning to appreciate the importance of the first 3 years of life in terms of brain development. We realize now that the first 3 years of life provide important opportunities to actually shape children's brains. Reading is one of those very special experiences.

Comment: I am curious because I have a pediatrician in my family. With managed care, he is finding more and more that he is allowed to spend very little time with patients. It is frustrating

for him because he feels that this inhibits his ability to do what he needs to do to take care of children. It would be difficult to find the time to address reading with parents. He would probably like the idea of volunteers in the waiting room, but having the message come from a professional makes it that much more important.

Jewkes: It is a question we always get in our continuous training sessions. We do a couple every month throughout the country for physicians. Many of our programs have residents who learn about literacy development as part of their training and then take it with them throughout their practice. The way that we frame it, however, so it will not become another item on a list of 20 other items when they only have 20 minutes, is to use the book as a developmental assessment tool. Doctors walk into the exam room, give the child the book, and watch the child's reaction. Doctors need to be assessing this anyway.

It is also a nice time to assess the relationship between the parent and the child and see what kind of interaction goes on around the book. That also presents the opportunity for anticipatory guidance. Oftentimes they frame it around what other developmental issues are going on at that time, such as if the infant is sleeping or crying a lot. Reading may be one way to calm him. It is in the context of all these other developmental issues that are being addressed.

We provide intensive training, giving the physicians the handouts and going through them with them to provide guidance as to what to do. It does not need to take extra time. Once they realize that they may already do it, they are very receptive. Once they start doing it, they all ask why they did not do it sooner.

We are moving to the point where this will be integrated into standard pediatric care. Encouragement of reading by pediatricians can start early, and it is valued. One listens to what one's doctor has to say. They are authority figures. If one hears something over and over again, just as if a child hears a story over and over again, one realizes there must be an important message there.

Conversation Hour—School Readiness

Edward Zigler, Willie Epps, Dollie Wolverton

Edward Zigler: I am one of the planners of Head Start. I was there before the summer of 1965 and have been there ever since in one capacity or another. School readiness and transition were issues at the very beginning and they are issues today.

Currently, we are going through a reauthorization of Head Start, and it is not a love-in. I am apprehensive. At both the Senate and the House hearings, it was very clear that the Republicans have an agenda. We have always been faced with the issue, "Does Head Start work?" I am not quite sure what that means. Historically, we oversold Head Start. I do not remember promising anybody that if you gave me a child for 1 year, I would make him perfect until he is 35. However, that is what we are expected to do, which is unrealistic.

In recent years, we have been trying reach some kind of a consensus. Head Start costs $4 billion a year. Congress and the taxpayers have every right to ask us what we are producing and whether we are accomplishing our goals. The fact is nobody within Head Start has been clear enough about what it is that we want to be held accountable for. As a result, we are letting other people tell us what we are accountable for.

It is 33 years into the game, and it strikes me that we ought to be honest and realistic. What is it we want to be held responsible for? Let us state it unequivocally. Let us not let other people impose their goals upon us, which is what they are trying to do right now.

I have been thinking about this since day one. It may be time to go back to day one. When we planned Head Start, I do not think there was any question in our minds that what we were doing was preparing children for school. There was not any ambiguity in our thoughts. Consonant with what Eleanor Maccoby told us, we knew that preparing a child for school was more than teaching them phonics. It had to do with his social relationships. However, right from the start, we were judged on whether we could raise IQs or not.

A great scholar named Herbert Birch, who is no longer with us, said to me, "Ed, why would anybody take the most stable measure that psychology has ever discovered and use change on that measure as the criterion of the success of a program?" I never thought IQ was all that important. All of us know many people with high IQs with whom we do not care to be in the same room. Eleanor Maccoby was right on target. Where is the character development?

Let me give you a little historical background. There were only two big innovations in Head Start. The first innovation was the comprehensive approach. Nobody was providing health care, nutrition, social services to the family, and so forth. We said if one is going to develop a child's readiness for school, one has to work on all these things.

Uri Bronfenbrenner was on that original planning committee and he was just developing the ecological model. Now everybody says the standard wisdom is two generation interventions. You have to work with the parents and you have to work with the child. Head Start did that. Therefore, the comprehensiveness was one great innovation.

The other innovation was parent involvement. There was recognition that Head Start centers do not raise children; parents raise children. We should do all we can to see that parents are as effective socializers of their children as possible. So that was what we did that turned out to be innovative. Now it is standard wisdom—of course. I am taking you back 33 years.

Now, can we all agree then that what we are about is school readiness? Is that important enough? Can we sell it? I think that we can.

There was an absolutely wonderful educational thinker in this country who died a couple of years ago, Ernest Boyer. Before he died, he conducted a study of school readiness. It was not classic science, frankly. How did he figure out who was school ready and who was not? He asked kindergarten teachers. They are really the ultimate criterion. We have all kinds of tests of school readiness, but if one wants to know if a child is ready, ask a kindergarten teacher. Just like you

could ask a Head Start teacher how a child is doing and get very good information. Boyer did a study nationwide and the outcome was very sad for this nation. He discovered that roughly 35% of American children show up at school not optimally ready to learn.

I know all the subtleties. Is the school ready for children? Are children ready for school? Let us not get into that. It is a fair expectation that a child knows certain basic things when he gets to school. He can count to ten. He can do simple things. If one looks at the actual school readiness measures, they are not rocket science. They are very simple, such as seeing if the child can tell the difference between a square and a circle, count to ten, and take turns. The superintendent in my own city of New Haven shared with me that on his school readiness measures, 65% of children are not ready for school. Those are the children that we serve in Head Start.

There are two other things I would like to discuss. One is that Washington is a political town. We all have to be smart enough—I did not start as a politician; I studied children and families. That is what I do. I have done it for almost 45 years. However, I have learned how this town functions. There is an act called the Educate America Act that has eight goals. There is a consensus among educators that the most important goal is the first goal: every child will show up ready to learn. Politically, it makes good sense to me for Head Start to say to the Clinton White House, for whom they work, "We are very interested in the first goal of the Educate America Act." I do not think it is being untrue to where Head Start started.

Let me tell you something else. The interesting thing about school readiness is that it predicts everything. It predicts whether a child is going to be in special education or not. It predicts whether a child is going to be in the right grade for his age or not. Every time a child is held back one grade, it costs $6,000 on average across this country. Special education is driving New York City bankrupt. We have to deal with cost effectiveness. School readiness is important politically because of the Educate America Act, and it is important educationally and psychologically because it tells you so much about the child. It is not as if I am saying let us pick something easy, something that we can do. It is hard. It is going to take all of our work to do that.

I was the conceptualizer that said, "Let us get away from IQ and make the goal of Head Start social competence." The National Head Start Association adopted it. So some people think that I am changing my tune. I think it was Emerson who said, "Foolish consistency is the hobgoblin of small minds." I am not being inconsistent, though. I wrote a paper in the American Psychologist about IQ versus social competence in the assessment of early intervention programs. In that paper I took on the IQ people and said that social competence should be our goal, not IQ.

However, regarding social competence, there are two major foci of the concept, one of which is meeting social expectancies. What is the most important social expectancy that we have for a 5-year-old child? It is being school ready. So I am saying it is a very short step from social competence to school readiness in my mind.

Willie Epps: I am from Southern Illinois University at Edwardsville. I was a Head Start Director for 10 years. For the last 4 years, I have been head of the Southern Illinois University, East St. Louis campus. Head Start is still housed on that campus. In 1988, a group came together and talked about the transition of children and families from Head Start to the public schools. At that time, we came up with the information on developmentally appropriate practice from NAEYC and Sue Bredecamp. We also took a look at why is it that children do not move from the known to the unknown without experiencing frustration and all kinds of anxiety. As a result, we started 12 projects looking at how we could get schools working together, communicating, and how we could start some pilots projects for getting children from one setting to the next setting.

One of the things we found out, and it was early on in the game, was that the public schools knew very little about Head Start. Therefore, one of our roles was to inform and educate the public schools about Head Start. Most of the educators' perceptions were that Head Start was a program where they sleep, eat, go on field trips, brush their teeth, and wash their hands. Basically, that is what they thought. We developed a set of materials and we set out to educate the public schools. That was 1988 and this is 10 years later.

One of the biggest problems that I find even 10 years later in terms of transitioning children from Head Start to the public schools is still the educative perception of what Head Start is all about. Public school educators are surprised to discover that we have a curriculum, that we use assessment tools, and that the things we do are developmentally appropriate.

The other thing—and it is probably one of the biggest surprises—is that we have qualified staff. They thought we actually had only mothers and fathers working with the children. They were surprised that there is a lot of training that goes into the program.

One of the things that we are trying to do is put together a transition planning team. In that team we will address the tasks that we need to accomplish. What are the tasks public schools need to accomplish? As a result, we developed a series of transition activities. Someone mentioned that we have a problem with the definition of transition. I personally believe transition is a process to help us get to continuity. Basically, what we are trying to do is make sure there is continuity between Head Start and kindergarten in the public schools.

The Administration for Children, Youth and Families has been focusing on transition for many years. The public school system is a bureaucracy, and that bureaucracy has been there longer than I have been in the world and it has not changed. I do not think it will make an adjustment for children and families. I do not think Head Start has the power or clout to change the public schools. If we start educating the public school sector and let it become their idea, then Head Start will participate with them. I do not see in my community, nor as I go around this country, those changes and adjustments being made.

I have two children and they are both grown now. Still on my payroll, but grown. When my son Willie got ready to go to college, he was 18 years old. Before he made the decision of where to go to school, he received invitations from colleges to complete their applications. He was accepted and decided to attend Amherst. The college wrote to us saying that before Willie could enter Amherst, we had to attend an orientation with him.

Think of this: 18 years old. We got in the car and drove from St. Louis, Missouri, to Amherst, Massachusetts. As a result, I got a chance to meet the president, the dean, and the lady of the cafeteria. She was a favorite because my son likes to eat. When we left Amherst, we felt very comfortable that Willie was going to be okay. We met his professors and other people that would be important people to him. Now, he was 18 years old and they demanded we come to Amherst for orientation? When my daughter got ready to go to Emory University, the same thing happened. I started thinking, if they are doing this for 18-year-olds and we have to go spend 2 or 3 days in orientation, what about a child 5 years of age who has to go into public school and fend and fight for himself?

The whole thing is that in Head Start we have to make sure when children leave us, they have the readiness skills to be successful in kindergarten. Public schools also have to make some adjustment, ensuring that schools are ready to receive those children.

This may be surprising to many of you. I think most of our children happen to be ready, but at the same time we have a large number of children who end up in special education. They are not in special education because of a lack of intelligence; they are in special education because of behavior problems. What happens when a Head Start child who knows how to write his name walks into a kindergarten classroom and his kindergarten teacher says, "This morning we are going to learn how to write our names." The little boy from Head Start says, "I already know how to write my name." She says, "We are going to learn how to write it again." As a result, he becomes a behavior problem. In many instances, we are duplicating the same curriculum.

We have to decide three things from pedagogic, structural, and philosophical standpoints. Someone said it this morning and it is true: most of the children who move up from Head Start to kindergarten move into ineffective public schools. I am not here to wage a war against public schools, but many of those schools are ineffective. I believe that if we had Head Start children in effective public schools, you would not hear the word "fadeout." Those children would continue to be successful.

How do we change the public schools? How do we reform those schools? In order to reform and change schools, we are going to have to work with parents. Dr. Zigler said it: we spend an exorbitant amount of money on parents in Head Start. They are on the policy council, they participate in training, and some go back to school. They observe in the classroom and they volunteer. When you add up the resources we spend on parents, it amounts to a large sum of money. Then one wonders why it is that parents do not go into the public schools and do the same thing. I ask, "Why do you not follow your children, since you participated in Head Start?" They say they do not feel welcome in the public schools. I try to tell them they are not there to feel welcome; they are there because the research says children whose parents participate in his or her education do better academically. They do better in terms of self-esteem and behavior. That is why they are there.

Another reason parents say they do not participate in the public school classroom is because they feel teachers do not listen to them unless they want them to sell candy or participate in some kind of fundraising strategy. The other thing parents say is that it is the teacher's job and not their job to teach children. When parents feel that way, there is a reason. When you look at the profile and the data of Head Start parents, 67% of Head Start parents nationwide do not have a high school diploma or a GED. Why should they become drum majors for the same public school that failed them or kicked them out or that they dropped out of? What we have to do in Head Start is to train parents to become effective in working with public schools.

We developed a program at Southern Illinois University that has been very successful. We have five modules that we put parents through. One of the first modules is showing parents they can make a difference. If they will not it for themselves, then we tell them to do it for their child. There are 10 ways that the research would suggest, by parents' participation in their child's education, that they can make a difference.

The second module we developed is how to familiarize parents with the public schools. Head Start is supposed to be an advocate for low-income children and families. When I surveyed Head Start's staff, 92% did not know anything about the public schools in terms of the Board of Education, how they are elected, when they meet, and where the central office is. How can you be an advocate for Head Start children when you do not know anything about the public schools? My recommendation is that all Head Start staff ought to become thoroughly familiar with the public school, not just the school in their community, but the central office and how the whole organizational structure functions.

The third module is how to work with your child at home. You do not have to have a Ph.D. It is simple things you can do at home to help your child maintain their self-confidence and their self-esteem. This includes how you talk to children. Some children coming from these homes only hear, "Sit down, shut up, and be quiet." We are talking about interacting with children.

Another module is how to introduce your child to the kindergarten teacher. That is always a big one. When my Willie started kindergarten, I went with him to meet his teacher. I said, "A genius is coming to your classroom. He's coming to a teacher who is also called a genius. You two will do wonderful things together. Here is my phone number. I'm here if you need me. We're working together as partners."

The last module is how to be an advocate for your child and for other children. I go to the Board of Education meetings every month and I see parents there representing the school. The Board of Education beats them up and says it is their fault, it is the society's fault, and it is their children's fault. Those parents leave with their heads down. It would be different if all the parents from the school came to the Board of Education and made the same demand. We have to teach parents how to do it and how to do it effectively, not in a confrontational manner. I believe that is how we will start making some changes in the public schools.

Zigler: It used to be that the easiest way to get a round of applause in a Head Start group was to say something negative about the public schools. Head Start parents hate the schools. However,

what Willie says is brilliant. He may well be a genius. The research literature is overwhelming in support of the fact that a child's progress in school is related to that parent's involvement in the schooling of their child. If you do not want to do it for yourself, do it for your children because it makes a difference. The kinds of modules that Dr. Epps is describing are exactly what we ought to have everywhere.

We heard a parent today who said she had to be a pain in the lower regions to work with the schools. She would not quit. We have some parents like that. On the other hand, I served on the committee for Program Improvement and Expansion a few years ago. We had a parent who was very active in Head Start. She told the panel, "It was just so traumatic for me because when I was in Head Start, I was on a policy council and I was welcome and everything was wonderful. Then my child moved to kindergarten and I went and tried to participate and they essentially ran me away."

Schools are huge bureaucracies, but they vary. Some schools are better than others are. What are people saying to me about fadeout? Valerie Lee, a very good researcher at the University of Michigan, has done work that shows so many Head Start children go on to very poor quality schools. That is why Russ Whitehurst's talk this morning was so important.

Children do not quit growing and developing when they leave Head Start. We cannot hate the schools. We do not have that luxury. We have to figure out how to interface Head Start with the schools and how to train parents to move from this setting to that setting. The kind of program that Dr. Epps is talking about sounds just terrific to me.

Saul Rosoff: I was visiting a center and I sat down during lunch in a little chair with a group of about five young children. This was in April. We were speaking about a number of things and the conversation turned to going into kindergarten. They lit up, they were enthusiastic, and comments were made such as, "Oh boy! We were taken to the school and we talked with the teachers and we saw what they had, and it was all so nice!" Uniformly, these five children all had the same upbeat, eyes lit, bells ringing experience. School was not anything that these children were afraid of. School was fun. That is what my experience was.

Patricia J. Gracey: I am from Wheeling, West Virginia, and I have been interested in knowing what is being done on a national level to get people from the Department of Education and the Head Start Bureau together to talk about such transition issues as curriculum, coordination, and cooperation. Is anything being done between the Department of Education and the Head Start Bureau?

Dollie Wolverton: Yes. As a matter of fact, we are working very closely with the Department of Education, Even Start, and Title One. One of the things that has been a great achievement on both sides is that Department of Education Title One programs are required now to implement the Head Start Program Performance Standards for the Child Development and Early Childhood Education section.

So we work together. They participated in some of the 70 focus groups. We had parents from Title One and other representation from Title One and Even Start programs. Together the performance standards have been developed. Both departments approved them. We worked together on the development of the guidance on which we have received a lot of good feedback as well. That is a major accomplishment. If we say that we are using the same regulations, the same program performance standards, that is a huge step forward in talking about continuity because that means that they are very conscious of what is happening in the preschool experience.

Andrew Kennedy: I am with the Los Angeles County Office of Education. There are 15 school districts, 15 nonprofit agencies, and a couple of city governments that work with me. So I have

schools that are advocates for Head Start as well as nonprofits and city governments. Many of our programs running Title One programs are not implementing early childhood education with their Title One funds. As we push toward new expansion, you are going to see an opportunity for school districts as well as the nonprofits to start working more closely together and start having their state-funded programs and their Head Start programs start wrapping around, supporting, and matching each other producing more integrated services.

Again, Head Start has to reposition itself as an early childhood development/education program because oftentimes we have a language barrier breakdown. It is also important to know that Head Start does not push itself as the model for change as schools do. For example, most schools are moving toward site-based management. Site-based management means parents are empowered to help select and hire teachers. They are also empowered in terms of reviewing the site budgets. Then there are a lot of programs like Healthy Start, which is Head Start's K–12 model.

I am fortunate to be able to speak from both houses because I was a principal in the K–12 world for 10–11 years. Then I became a Head Start director. I have both state and federal categorical programs, from migrant education to special education as well as vocational education programs. Seeing the whole picture, the Healthy Start models need to be infused with Head Start. That means that Head Start needs to let them know that to educate a child properly in the K–12 world you need to have community involvement, deeper parent involvement, and support systems built in that are going to make a child more successful.

Head Start should market and position itself as the leader, such as I have done in Los Angeles County. I have met with the superintendents, the boards, and community representatives, and have said, "Now you have Healthy Start. Do you know the genesis of that?" Then they look at Head Start and say Head Start really had all of this before we had these designs.

My thoughts are that again, as Dr. Epps identified, the boards are not educated about what the integrated model of Head Start is about. However, they are starting to understand that. When we talk about developmental education from the early childhood perspective, it is important to say developmental learning all the way to the 12th-grade level and into adult education. All of you who have taught adult education, K–12 or elementary education know that you train children in elementary school with developmental-type techniques. This is also true in high school. So, if you follow the whole continuum of learning, you can see the integrativeness. Head Start people have to speak from that perspective rather than limiting themselves to the 0 to 5 perspective.

Wolverton: Are you aware that in August there will be a national transition meeting co-sponsored by the National Head Start Association, the Department of Education, the National Association of Elementary School Principals, and the Head Start Bureau? It will be here in Washington, DC, and we hope you will participate.

Reference was made to a major transition demonstration that took place over 7 years in 32 communities. Do we have staff from any of those communities in the room? Would you be so kind as to contribute and tell us about your experiences? I would like to emphasize that these demonstrations were Head Start through grade 3. It would be wonderful to hear what you have to offer us.

Comment: I am from Fairfax County, Virginia. There was a discussion earlier about what transition is truly about. Is it about preparing children for school or is it about system change in terms of the public schools? We did a fairly good job on working with the educational program in the schools. I think that we did not do as good a job in providing comprehensive services for children in kindergarten through third grade. However, it is important to recognize the issue of parents feeling that when their children went through the public school system, they were not as supported, nurtured, or welcomed, in contrast to how it had been in Head Start. I do not know

how to address that issue, but I do know it was very hard for a Head Start program, which is a small program, to expect to be part of the overall system change. I do think that on a school-to-school basis, and a teacher-to-teacher basis, it probably had some very good results. I think it was quite an undertaking, though. If what you were saying, Dr. Zigler, is correct, and if what we should be evaluating Head Start on is whether children are ready for public school, then we are still hitting that same barrier once they hit public school.

Zigler: Head Start has been a national laboratory from day one. Early on, I saw with Project Continuity that we had to get into the schools and do something about that system. So I worked with Senator Kennedy to put the transition project into place. I have been trying to stay up with the Rameys who are doing the evaluation. Could you tell us anything about the evaluation and whether it is proving to be successful or what is going on with the outcomes at your site?

Comment: Essentially, we sent the data to Alabama and we have not heard back yet. Local evaluations were looking at process and the difficulties in the process. In terms of children's test scores, all the data has been sent to Alabama.

Wolverton: This is the year that they are putting it together.

Linda Spatig: I am Linda Spadig from Marshall University in West Virginia and was also involved with the transition demonstration project. I was part of the evaluation team, specifically the qualitative evaluation. I wanted to point out that the data we collected were the observational and interview data—the narrative data. We did a lot of what was mentioned earlier about talking with teachers, parents, children, staff, and so forth. We found some interesting things in terms of how people perceived different issues. For example, many of the teachers with whom we worked perceived a basic inconsistency or incompatibility between what they needed to do to get standardized test scores where they should be—according to the district—and what our project was pushing in terms of developmentally oriented practices. There may not be an inconsistency there, but the point was that they perceived it and felt pulled.

How do we come to some agreement on defining what it means to be ready for school? Then, what does it mean to do well in school? Is it a test score? Is it something else? Is it learning to count to 10? Do we have a list we could agree on? Otherwise it does not mean much.

Zigler: It is silly to talk about school readiness as our goal if we are not prepared to, what we call in the trade, operationalize the construct. You have to have measures that define the construct. I think that the FACES effort that has been discussed at this meeting is trying to do exactly that. There are a lot of other people working on this. Lynn Kagan has organized a group that is addressing this issue. There is a kind of a general consensus developing. Chaya Piotrkowski at Fordham is asking parents, Head Start teachers, and kindergarten teachers what they think school readiness is.

We are trying to develop a consensus. The big effort with which I am helping the Administration for Children, Youth and Families now is the FACES effort. We have to make sure that they tap the kinds of things that Eleanor Maccoby was describing, not just cognitive areas. You have to get at children's emotional self—can they self-regulate? Do they become behavior problems? Carole Ripple is evaluating a program in Head Start where these children are already unable to be Head Start children. They have to get special help. That is at the age of 4.

So what does it take to get a child ready for school? The evidence is overwhelming that preschool can be a big help. Even with Head Start, which is helping us do a little bit better on the numbers, we live in a society in which there is a huge correlation between how much money a family makes and whether the child gets a preschool experience or not. What middle-class

family does not send their child to preschool? We all did. The children who need it the most—poor children—are not getting it.

So the two big things that are going to produce school readiness is a good, developmentally appropriate preschool program and good health. If a child is not healthy, nothing else matters. Sick children are not ready. It has always bothered me that Head Start has never gotten the credit it deserves for the health component that we have had. That is why the Healthy Start business is very important. They are finally getting the message. It took a little while, but it is a good message to get.

The defining feature is going to be the FACES effort. That is why we have all got to be involved. When they define that construct in the FACES effort, we are betting the whole ballgame on those measures. So we have got to make sure their measures are valid and appropriate.

The Government Accounting Office (GAO) did a new evaluation of Head Start. For those of you who do not know it, the GAO is a kind of watchdog of Congress. Any member of Congress could tell them, "Investigate something." So they are investigating, after over 3 decades of giving to Head Start, whether Head Start works or not. The conclusion was that they do not have the evidence one way or the other.

Representatives of the GAO were at the hearings we attended and I do not agree with the GAO. It is not because I love Head Start. I am still a hardnosed scholar; I look at the evidence. We have paper after paper that shows that children who have attended a preschool, whether it is Head Start or some other preschool program, are simply more school ready by whatever school readiness measures are currently used.

On the test issue, that is a tough one. Why have schools become so fixated on test scores? They are highly correlated with IQ, by .7, which means half the variation on one predicts the other. There are so many other things that are not measured. Is that going to go away? I do not think so. On the other hand, I could point you to data such as a study done in New Haven, Bridgeport, and Hartford with poor children in the inner cities. Those children were doing better compared to children who did not have preschool. They were doing better on fourth grade mastery tests. There is a curriculum debate that will be with us forever.

If you are in a developmentally appropriate classroom in Head Start, you can have the Bank Street model or the High Scope model. There are many good curricula models. Then, suddenly, you show up in kindergarten and it is a whole different ballgame. That would be tough enough for an adult to do, never mind a child. They have you do things you already know. Blasting the schools and complaining about them is an empty enterprise. We have to help educate them and we have to work with them. The fact is that the developmentally appropriate practices of Head Start are not out of place in kindergarten or first grade, for that matter. More and more schools are moving in that direction, as you have suggested.

So we need to try to get that kind of continuity, because discontinuity is very tough on children. Part of that continuity, however, is the parent who can navigate the child through all of that if the parent is prepared to do so. I see more progress than things to be unhappy about. It has just taken longer than most of us would have liked, and some of us are running out of years.

Wolverton: Could you please tell us about your experiences in continuity through grade 3?

Cathia Darling: I am from the Miami site Transition Project. We have six regions in our school district. In each region there are about 75 schools. The Transition Project was located in Region Six, which is the southern-most region of our school district and it is the region that was hit the hardest by Hurricane Andrew. Because our project started the year after Andrew, we lost all of our families and had to recoup them through a variety of methods. The thing that what I learned the most was the importance of institutionalization.

In Dade County, accountability is running rampant. We are looking very carefully and closely at children's test scores. I do not think it will ever go away. We now have in our system a

developmental comprehensive reading plan, where children will be retained if they are not reading by second grade. They will be retained for however long it takes, and this is board-approved.

I am now the transition coordinator and I believe parents are the key. If parents do not begin to understand and try to align themselves with us, the school district, then we will lose more children than we have lost already, especially in Miami. Institutionalization was okay because I only had four schools. However, now I have over 275 elementary schools. I am trying to get our Head Start to understand that transition is not an event, it is a process. It cannot start with two visits to our kindergarten classrooms; it has to start from the 0 to 3 point.

We have to keep badgering parents like we did in transition to help them understand that they need to come out and take the responsibility for helping their child navigate through the very difficult waters of public school. At least we have children with parents—hopefully when they arrive at our doorstep—who will begin to understand that even if they do not feel welcome, they better knock the doors down and try to get in there. Forget the welcome stuff. They felt very welcome in Head Start and that is all well and good. However, you may not necessarily find that warmth in many of our classes.

I have to say this in defense of public schools. It is not that we do not care; it is just that we have never been taught to do the kinds of things that Head Starts has done for so many years, and have done so wonderfully well. It will take a re-education of the school system because many public school teachers think Head Start teachers do nothing. Then Head Start teachers think we know everything. What I am trying to do is bridge that gap smoothly, without stepping on toes and without upsetting turf, and move in a direction with Head Start and the school system where they have never been before: getting them to talk to each other.

We met informally with kindergarten teachers in about 15 or 16 schools, which is not a representative sample. We asked the Head Start education coordinator, "What kinds of things do you think children need when they come to public schools?" It was not academics. They were more concerned with social competence. If Head Start and public schools continue to work together we can do this. We have to do it for children.

Elsa Brizzi: I am from Los Angeles and am with Andrew Kennedy. I would like to share the idea of resources. Public schools are in desperate need of human resources in classrooms. Every child in a class is different, requiring teachers to deal with individualized instruction with little help. I have been working very hard on training teachers as supervisors of other adults and applying the same model medical doctors use in looking at teacher assistants. Schools think ancillary help are gophers, and still think of teachers as the one human being doing the whole job.

At Head Start, everybody comes to school and helps. If we could begin to have some incentives for our Head Start parents to get into the classrooms and help teachers, and then help teachers see that they can work with other adults in doing the kind of job they do, I think everyone benefits. Our children benefit, our teachers benefit, and our schools benefit. Therefore, it is all about looking at how we use human resources and how Head Start gets parents into classrooms—kindergarten classrooms and primary classrooms—to help their children learn and help teachers do their job.

Epps: Even though parents are often referred to as "hard-to-reach parents," "cannot be found parents," that they are lazy, they do not care about the education of their children, and so forth, one of the things I know is that all parents care. All parents love their children. Many just do not know how to express that love, and they do it in different ways.

A couple of years ago, we asked parents some simple questions. We asked them to give the official name of their child's elementary school and it's address. Eighty-two percent of our Head Start parents could not tell us the official name and address of their child's elementary school. This is serious. Another question asked what time your child eats lunch and where. We had

about 62% of parents who could not even tell us what time their child had lunch.

The third question was to name their child's kindergarten teacher. They could not give the name. They would describe her. They would say, "She is a little stout lady with long hair." All I am saying is that at that point those parents were not involved in the school.

The National Head Start Association commissioned us to develop a booklet called "Connecting Head Start Parents to a Public School Setting." I would like to quickly run through it. The first part covered the 10 reasons parents usually get involved.

The second part is, "Introducing your child to the kindergarten teacher." We include all the dialogue in terms of the words parents need to say. Do not send your child to kindergarten; take your child to the kindergarten teacher and introduce him.

Another piece that we have is, "Whom do you need to know?" What we are saying here is that they need to know the superintendent, the board president, their child's kindergarten teacher, and the school principal.

We also ask, "What are the important telephone numbers? Do you know the telephone number of your child's school?" We discovered in our survey that many parents answered no. In the booklet, we instruct parents to get this information from the kindergarten teacher when they take their child to school the first day.

Every parent is entitled to a parent/child handbook. Parents say "If you want me to know the policies and procedures of the school, you ought to give me a parent/teacher handbook. How can I support and enforce the rules and regulations of the school if I do not know them and you do not give me anything?" What happens when the school says they do not have one? I suggest that parents tell them to get one.

Another thing we say is, "What is the school calendar?" Some schools in the district where we are do not even give parents a school calendar. They do not know when the children are in school or when they are going to be out. When are the PTA meetings? Parents responded, "We do not have a PTA." We ask, "You were on the policy council in Head Start, so why not get the other parents and start a PTA?" Parents continue, "They will not allow us to." We counter with "Who will not allow you to? You can start it. That is your individual right."

Here is the piece that I like. What would happen if a low-income parent walked into a kindergarten classroom, talking about his or her child, and asked, "What can I expect my child to learn in kindergarten?" The teachers are going to have a hemorrhage. In most urban schools, teachers do not give parents an expectation of what the goal is in that particular classroom. I tell parents they should initiate it, watch the teachers, and ask, "What can my child expect? What can I expect my child to learn?"

The next part is what parents can do at home to help their child. We include some easy things parents can do.

Another part is the parent/teacher conference. Almost invariably in almost every urban school, teachers say parents do not show up. Second, they do not have anything to contribute. The parent/teacher conference is not the teacher conference. It is parents and teacher conference. Therefore, we go through role-playing with parents illustrating how they may participate in parent and teacher conferences. It is not just that your child is pretty. You are not in a beauty contest. How is my child doing academically? How is my child progressing? What is she doing? What are some of the problems she is experiencing? What are some things I need to know?

We also say to parents, before you go to that parent/teacher conference make sure you talk to your child. What are some problems your child is having with the teacher? Parents need to know this so that they can discuss it with the teacher in the conference.

We also give them some conference tips. We have a lot of Head Start parents and probably public schools parents who do not really know that they have real rights and responsibilities. I tell people that they have rights on the one hand, but responsibilities on the other.

The last thing that we put together was an activity for June, July, and August that they ought to be working on with their child. These activities do not cost anything. In August, we tell

parents to take their child by the school to let him see where he will be going. Take the route he will be taking, even if it is on a bus. Get school supplies, but wait until the teacher tells the child to get the supplies. Wal-Mart, K-Mart, and so forth have gotten filthy rich because parents go and buy all kinds of stuff, and then the children get to school and the teacher hands them a list. We say wait and let the teacher give you a list of necessary items.

It is a wonderful little book. It is being distributed through the National Head Start Association. Every parent in the world should have one. Dr. Zigler, I know you are not a parent, but here is a copy for you.

Zigler: I am a parent.

Epps: I mean you do not have one going into kindergarten.

Zigler: No, I do not, but I will soon though.

Epps: A grandchild.

Zigler: Yes, a grandchild.

Sarah Unruh: I work at the U.S. Department of Education. This conference has done a good job of bringing together researchers and parents as well as people working on programming and health aspects. However, as a former preschool teacher, I feel that the teachers have not been voicing their concerns here, especially in conversations on school readiness. If teachers were here, they would learn a lot and people would learn from them.

Comment: We are sending a team to the transition conference and we selected the West Virginia Northern Panhandle Head Start. We selected the school district with which we have the closest relationship. Their curriculum specialist is the Chairman of our Board of Directors. We asked them to pick a teacher or an administrator to come with our transition team. To date they have not come up with anyone. They thought a kindergarten teacher would be the person to come. I would have preferred a principal. However, they still have not been able to find anyone to agree to come free of charge to this transition conference with us.

Comment: Most teachers are off during the summer when the conference is scheduled.

Wolverton: When would you recommend such a conference take place?

Comment: For us, the summer is the best time. It would probably be terrible for us if it were in September.

Andrew Kennedy: You are talking about 10-month programs. In Los Angeles County, just as I am sure in New York, Chicago, and other major large school district areas, we have year-round programs. So this time is as good as any. During the summer, a large percentage of our school staff go to summer institutes. Throughout Los Angeles County, we are sending a lot of teachers to science training workshops for early childhood programs.

The only point I want to raise is about what we started in California. I believe the NHSA has a national partnership with the PTA. Therefore, if you start from the bottom up, what we have done is try to bring in the California PTAs in partnership with our policy councils. In the PTA, one can start a PTA right in one's policy council. There can also be a Head Start-PTA combined. Then parents transition into the next school district already ready to take a leadership role where there are no leaders. Then you bring in your PTAs and have liaisons.

Every policy council and policy committee in L.A. County at the different delegate agencies elect a PTA liaison as one of their officers on their boards. That PTA liaison then will serve as the one who gathers the parents together to do the transition.

Then you also get your PTAs to elect a PTA Head Start liaison and they come together as a unit to work together. Therefore, you are going to see the dynamic duo of the PTA who advocates parents' involvement in schools and parents in Head Start who advocate the best for their child in terms of school and make that fusion work together. During the summer and when you are moving into September would be a good time to do it. In Head Start, for parents who cannot afford the $5 to be a part of the PTA, you can put that into your Head Start parent involvement budget. PTAs have school readiness plans that can serve as a transition.

The question is: Are we starting to move together with the Department of Education, Department of Health and Human Services, and other types of child care divisions for continuity of curriculum, instruction, and assessment? I am not talking about as a national model, but as a recognition that different components are needed in order to be able to describe what some of the cognitive, affective, social motor, and school readiness characteristics are that schools need to look at?

Schools in general, along with their Head Start nonprofits, can do that on the local level, but if there is an emphasis at the national level to show that partnerships are developing, than we could go to the Governors' conventions and talk to them about this. When we bring it into the superintendents' meetings to remind them of this, then you will start seeing the integration of what school readiness is from affective, cognitive, psychomotor, and socioemotional curriculum perspectives.

Wolverton: I think we are probably at a pretty good point where that could be done. We have the International Reading Association, NAEYC statement on reading, and the Preventing Reading Difficulties study. We have a richness of resources, FACES, and some other things, and this would be a good time to do it.

I want to inform you of something else that the Department of Education and the Head Start Bureau have done in conjunction with the Girl Scouts of the USA. Working together in recent years, we have developed a new level of girl scouting called Daisy Girl Scouts. It starts with the Head Start girls working with their parents during their last year of Head Start and during the summer. The parents are the scout leaders—both mothers and fathers. Volunteers sew the jumpers that the girls wear. The summer is devoted to all sorts of cultural activities together with the families. They visit museums and libraries and see ballets. All these kinds of activities are built in. When they get to kindergarten in the public school setting, then they are Daisy Girl Scouts in the kindergarten setting. That is just a small illustration, but it is a powerful one. It is taking place in many communities around the country and it is helping to bring us together as Head Start, schools, and national organizations which have a lot to offer.

Emily Mann: I am with the Chicago Longitudinal Study on the Child/Parent Centers. I am also a social worker, and just finished an internship in the Madison public schools. So I have both things going on in my head. One of the things that has been plaguing me is parent involvement and welfare reform. I cannot put these two pieces together because there are not that many hours in the day to be an active parent, to do all those wonderful things that you were describing in your manual, be mandated to work, not have transportation, and be a low-income parent.

Another thing on my mind is that some schools do not even have social workers. They do not have the mental health services or the nutritional services to supplement public schools. So there are all these things that are tugging on me and I do not exactly know how we are going to get parent involvement to fit into America's welfare-to-work mode.

Epps: I hope you do not fall into the trap that a lot of social workers fall into. Even before

welfare, there were poor people. My mother and father were not only poor, "they was po." There were five of us and they were able to balance their schedule with some kind of equilibrium so they could go to PTA meetings. Both never had any formal schooling, but they were able to do it and they valued education. I am simply saying I do not want social workers crying over these people, saying they cannot make it. You have to assume your responsibility as a parent.

The other thing you say is that they have no transportation. Oh, isn't that too bad? However, you can see them at happy hour, and no yellow buses go out there. How did they get there? Or they say, "We do not have a babysitter." I have never seen a babysitter in the lounge. I have never seen a child or a baby in the lounge. How did they get there? Think about it. We get what we want to get and we get where we want to get when we want to get there.

Do not say we need to find a babysitter for them. They can find their own babysitter. If they say they cannot come to a policy council meeting unless you go pick them up, that is not true. Or perhaps they say they are not coming to a banquet unless you pick them up. Make the announcement and say you expect them to be there. I am serious. Do not hand-feed them. That is what we have done too long for too many of our parents.

Mann: I want schools to meet them halfway. If there is a parent meeting and there is no child care provided—

Epps: Why do they need child care provided for a school meeting?

Mann: So you can get parents there.

Epps: Parents have to get there; not for themselves, but for their children.

Zigler: The truth is somewhere in the middle. We should expect parents to do all this. However, what I hear when I visit Head Start programs is that the welfare reform effort has made it very difficult for the parent participation component. There are only so many hours in the day. The thing you have to remember, something that we should all know, is let us not make the mistake we made in 1965 when we thought all poor parents were all alike. Some of the parents are going to do exactly what you say. Other parents are going to need a heck of a lot more help. That is just the reality of things.

Epps: I agree with you. I do not mean to sound hard, but we have to start empowering our parents so that where schools do not have nutrition services, they will be able to go get nutritional services. The other thing is that Head Start cannot continue operating in the mode we have been operating in. When you say you do not have a good parent involvement component, it all cannot be from 8 a.m. to 4:30 p.m. We have to look at flexible scheduling in order to get these parents to participate.

Another thing to ask is to what degree and at what level do I want parents involved? I want the parent to get up in the morning and get the child up and have the child ready to go to school. I do not want the child coming to the door, the parent sticking her head out of the door with rollers in her hair saying he is not going today. A parent's responsibility is to get up and get the child ready and make sure the child is ready to learn that day. I look at that as a part of the whole parent involvement scheme. What I am saying is that we are going to have to look at some other kind of flexible scheduling in how we work with parents, not just 8 a.m. to 4:30 p.m.

Comment: Today when Eleanor Maccoby was talking about Japan, I was thinking about the reauthorization and how we have to prove that Head Start works. I used to live in Japan and I had a baby in Japan. They would say to me as I took my baby around, "In Japan at this time we sleep our babies like this. How do you put your babies to sleep?" I said, "I do it this way and my

neighbor did it that way." We would go through so many different things. I could never say, "In America we do it this way." However, they could say, "In Japan we do it this way."

We go to Head Start and expect one way of doing things and expect that one set of research results are going to work for all across the United States. It is so much messier and more difficult than that, which is why we have had these difficulties since 1965 proving certain things. We do things in many different ways, which makes it much harder.

The other comment is about parents. I have felt over the years that we are putting an enormous responsibility on parents to do what we as educators should be doing. We say parents should read to their children. Of course parents should read to their children, but somehow I think we are putting responsibilities onto parents because maybe we are not doing our jobs well enough. It is just something to think about because it always worries me.

Townley Rhitz: I am with the National Head Start Association, the Government Affairs Division. It is has been interesting sitting here, talking and listening to everybody discuss what we need to be accountable for, what we need to measure in our programs, and what we need to do for our performance standards.

As Dr. Zigler alluded to earlier, we are in a reauthorization period right now. I wanted to let you know what Congress is going to be expecting of Head Start in the years to come. Specifically, additional educational performance standards have been proposed on the Senate side. These standards are being proposed to insure that the children participating in the program at a minimum develop phonemic, print, and numeracy awareness, understand and use oral language to communicate needs, wants, and thoughts, understand and use increasingly complex and varied vocabulary, develop and demonstrate an appreciation of books, and in the case of non-English background children, progress toward acquisition of the English language. They have actually introduced a bill. That is the only thing we definitely know for sure and can discuss.

As Dr. Zigler testified in June, he felt these were things that should be on the measurement side. I want to let you know that they are now on the standards side from the Senate bill. So Congress has taken it upon themselves as well to decide what they want to see happen in Head Start down the line.

Epps: What is the chance of that being approved?

Rhitz: It is very high. The House has basically taken the Senate bill and added some more provisions to it. We have not seen if what they are proposing is going to be in the draft language, but in the House bill they have proposed going further with the measures, not putting them in standards, but looking at knowing that alphabet letters are a special category of visual graphics, recognizing a word is a unit of print, and associating sounds with written names.

Zigler: That is very helpful. I should point out to the individual members of Congress and their staffs that this is a very big change for Head Start. Not even Head Start micromanages to the extent that Congress is trying to micromanage this program. The strength and richness of Head Start has been that it is community-based. It is doing what it wants to do. Granted, we have components and we have performance standards, which I like. However, we give a lot of autonomy to the local Head Start center.

My gut feeling is that the House is going to be tougher than the Senate. There is this desire to micromanage this program from the level of Congress. How much of it could we dance around and how much of it are we going to have to do still remains to be seen.

Head Start has had a "Perils of Pauline" existence from day one. They love us for a while, then they hate us, then they love us again, and then they hate us again. I have been watching it for 33

years and it does not ever seem to change. This is a brand new development that I have not seen in over three decades. How we are all going to deal with it is going to be telling.

I do not think we have many degrees of freedom. We are going to have to do what the law requires us to do. However, that is why it is so important. We have to have many people testifying because people tune me out too. Most people know what I am going to say before I say it. I do not know why they even invite me to come.

The fact of the matter is, though, that those of you who are in Head Start and those of you who are in public schools care that those children are going to be yours eventually. It is one of the roles that we can never ever give up, and it takes a lot of time and effort. That is why I appreciate the National Head Start Association and the Children's Defense Fund so much. It is not that we are without advocates, but we cannot leave it only to them.

I have discovered over many years in this town that members of Congress listen to the people from their districts. So I am imploring you, no matter how busy you are, to write letters to a member of Congress in your district. An honest letter still carries a great deal of weight. You would think after three decades I would not be giving this sermon, but the fact of the matter is all of us who care about Head Start have to keep advocating and educating. Some of these people are asking for things that we have been doing for a long time. Invite that member of Congress to your Head Start center when he or she is in the district.

The one thing I have discovered is that if you can get decision makers, whether it is the Secretary of Health and Human Services or a member of Congress, to your center and have them talk to parents and have them see the program, that is almost the best advocacy that you can do. It makes believers of them. You can read the evidence, but whether you see the glass half full or half empty depends on your biases. However, if you are engaged and talk to the Dr. Eppses of this world it makes a big difference. We have worked at it and we are just going to have to keep working at it. I am afraid it will be with us for as far into the future as I can see. So do not ever give up your advocacy and do not just let the National Head Start Association or the Children's Defense Fund do it all for you. Do it as individuals.

Sarah Franze: I am from the Georgia State Research Center on Head Start Quality. One of the original tenets of Head Start was to also help the family, not just the child. So it seems to me that the family is sort of a lost area. I was wondering if you could give some thoughts or ideas on what Head Start goals are for the family, not just regarding involvement, but also personal goals for the parents.

Zigler: You may not like what I have to say, but I will be glad to say it. There has been a debate going on, and it is a friendly debate. Friends of mine have said Head Start ought to concentrate on getting parents jobs, helping them with their mental health problems, or this or that or the next thing. That is a perfectly legitimate point of view. I am not yet convinced that Congress cares that much about poor adults. We get no Brownie points whatsoever by helping adults. When we go to Congress and testify that one third of parents are Head Start employees, we do not get much out of that. What people want to see is how children are better as a result of being involved in Head Start.

We knew that if you want to impact the healthy growth and development of children, you must work with families where the emphasis is upon how they socialize their children and how they can improve children's lives. That may involve brokering all kinds of services. We have a vast amount of literature on this issue. If a mother is depressed, she is not a very good socializer of her child. She is irritable. If we want that child to do well, we had better do something about the mental health of the parent.

My position over a very long time has been to stay child-focused. Where you will get brownie points is if you could show with observational studies that the parent interacts with her/his child in a manner that is more conducive to that child's total development.

I do not know the formal position of the Head Start Bureau. I do know, however, that unless we can demonstrate real progress in children's development, Head Start will not be with us very long. It is a matter of the survival of this program. Do I want to do more work with parents? Is that important? Yes. However, if that is your goal you are going to lose because Congress does not care that much about the parents.

Do not think that Head Start can do everything. We have a limited and constrained budget. Eleanor Maccoby told us she would quadruple our budget today if we were to do all the things that she would like us to do. They all make good sense. Who does not want to do all those things? However, Head Start is not going to end poverty. There are many things that are beyond us. Those of us who care about children advocate for that. We have Bronfenbrenner's ecological model now. We know all the forces that go into children's development. My position over the years, though, has been to be focused on that point. We have plenty of data that say the most important determinant of a child's growth and development is the experiences that child has in his family. The family is the most important. If we try to pick up what we call variance in children's behavior, it is family characteristics that are tremendously important.

If you care about the development of children, you have to work with the family. Head Start has been doing that a long time. There are people that would like us to spend our money doing much more for parents. However, as long as Congress does not believe we are doing enough for children, how can we do that? I am the first to admit that this is a debate. I have had this debate with people who are friends of mine. Somebody, though, will have to make the call. I do not have to make it; the Head Start Bureau has to make it.

Wolverton: That is a position that is supported by Helen Taylor, the Associate Commissioner. It is also the Head Start Bureau position. The first section of the Head Start program performance standards is focused on the child: comprehensive health, mental health, dental health, nutrition, education services, and so forth. The second section is on families and community. The third section is on management and program design. So of course, we work with the family, but it is clearly a program focused on the child.

Joyce Rawlings: I was listening to what Dr. Epps was saying about parental involvement. I do understand that we let families off the hook sometimes. We must also, however, look at celebrating families who are involved in nontraditional ways. Family involvement does not mean being in the classroom. If I never see a family in the classroom and the child is progressing and is getting schooled, fed, clothed, loved, nurtured, that family is involved. This clearly was pointed out when we did a RIF reading challenge program for 2 weeks. We sent a book home each day with the children. A family member had to read it. We did not care who that family member was. It could be the child's brother, sister, uncle, aunt, mother, and so forth. Someone in that family read the book, sent it back, and the child put her little tag on the wall. That is a small thing, but it linked the family to the school in ways that we had never done before. They had to do something every day. In September when we reopen, we are thinking about doing it every day because we saw a clear link. The children went home and pressed family members to read to them. It opened up communication. It broke down some of those barriers. Do not limit the ways that families can be involved with their children's education. It is not only coming to a parent meeting at night and being in the classroom volunteering. That is not possible for a lot of families.

I am a single parent too and I raised three children myself. My children started in Head Start. I can empathize with what Dr. Epps is saying because I made the sacrifice. I worked two jobs and went to the meetings too. However, there are families that are not at that level. We are all at different levels of growth. We have to accept where they are and whatever small thing they do and celebrate it so they can rise to do more things with their families.

The other thing I wanted to say was that Head Start needs to stop saying "must" to families

when they ask for involvement and say "should." We would like the parents to be involved; we strongly urge them to be involved. It leaves staff and community persons with a feeling that you are saying that you want stronger parent participation, but you are not giving them any ammunition. You are not giving them any tools to say that "you must" when we are offering this service to children and families at no cost.

Wolverton: This has been considered over and over again, and was discussed with 70 focus groups we convened regarding their vision of the performance standards. The reason why we do not say "must" is because we do not want to eliminate any child from the program because their parents do not choose to participate. That is the answer to that one.

Marlene Midget: I am from Northern Panhandle Head Start in Wheeling, West Virginia. I wanted to add another point about parent involvement to what Dr. Epps and Dr. Zigler said. In Head Start sometimes we limit parents because we think they have low incomes. I did not hear the word respect. If we respect who they are and expect them to be involved in their child's education, they will. Would we put the same conditions on middle-class families that we have put on Head Start parents? Would we expect them not to be involved? We were poor a long time ago, were we not?

Zigler: I have enjoyed this a lot. I am very grateful to Dolly Wolverton for helping us out. As per usual, Head Start people manage. I do not know if I taught you anything, but you have certainly taught me a lot.

Language Development of Linguistically Diverse Children in Head Start Classrooms: Three Ethnographic Portraits

CHAIR: Catherine Snow
DISCUSSANT: Cynthia Garcia Coll
PRESENTERS: Mariela Paez, Consuelo Aceves, Anne Wolf

In a recent national survey, it was found that Head Start classrooms have experienced a sharp increase in the number of children enrolled from other than English-speaking homes (SocioTechnical Research Applications, Inc.,1996). The survey reported that 22% of Head Start children now speak Spanish at home and another 4% come from families that speak any 1 of 139 other home languages. The impact of Head Start programs on children from other than English-speaking homes, particularly in terms of language development, is, consequently, a critical area of research.

The findings to be reported in this symposium were developed as part of the research program of one of the members of the Consortium on Head Start Quality. Using an ethnographic approach, researchers collected extensive data throughout the 1996-1997 school year in three different communities, each with a distinct type of Head Start classroom situation—a bilingual Spanish-English classroom, a first language classroom in Spanish, and an English language classroom serving children from a variety of home language backgrounds (Tabors, 1997, Chapter 1). Audio and videotape data, interview data, and field notes were used to develop the portraits of these three classrooms and the strikingly different types of language development experiences that they afforded.

The discussant will draw both educational and policy implications concerning language use and development in Head Start classrooms serving linguistically diverse children.

References

SocioTechnical Applications Research, Inc. (1996). *Report on the ACYF bilingual/multicultural survey.* Washington, DC: The Head Start Bureau.

Tabors, P. (1997). *One child, two languages: A guide for preschool educators of children learning English as a second language.* Baltimore: Paul H. Brookes.

■ Portrait of a Spanish-English Bilingual Head Start Classroom

Mariela Paez

Research has shown that patterns of language use play a critical role in supporting children's linguistic, intellectual, and social development (Snow, 1983). The development of oral language and patterns of language use start very early for children in their home environment and can be impacted by children's participation in classroom settings. Because of the importance of school environments in shaping the language of children, and the fact that very little is known about the language experiences of bilingual children in preschool classrooms, the language environment and language use patterns in a bilingual Head Start classroom were examined.

The data for this study were collected through this researchers ethnographic work during a 6-month period as a participant-observer in a bilingual Head Start classroom. The classroom was bilingual in the sense that both the lead teacher and assistant teacher spoke both Spanish

and English in the classroom and, of the 18 children enrolled in the classroom, all but 2 spoke at least some Spanish. There were two groups of Spanish speakers represented in this classroom: children of Puerto Rican descent and children of Central and South American descent. In addition, there was one Vietnamese native speaker and one native English speaker in the classroom.

A portrait of this classroom is presented through a description of the general language environment and language use patterns of teachers and children in the class. Typically, second-language learners enter Head Start programs and are faced with the challenge of adapting to a classroom where English is the primary language. Unlike a typical Head Start class, the teachers in this classroom created a bilingual, multicultural environment. Both the lead teacher and her assistant welcomed the home languages of all their students and paid particular attention to the different cultures and different dialects of the children in the class. Moreover, the teachers in this classroom demonstrated specific patterns of language use when addressing different children. Both teachers had some notion of their students' language knowledge, and they tried to match this to their choice of language for communicating.

Observations, field notes, and audio-recordings of children's interactions and communication patterns showed that, although most children spoke English and Spanish, their levels of proficiency in these languages varied greatly. Some children in the class were Spanish-dominant, that is, they used primarily Spanish in the classroom even though they might know some English. Other children were English-dominant, i.e., they spoke primarily English although they might also know Spanish. Yet other children seemed to be fluent bilinguals, in that they were able to use both Spanish and English and could easily change from one language to another depending on the situation. Finally, there was a Vietnamese child in the classroom who was in the process of learning both languages. Overall, the language diversity in this classroom allowed children with different skills to interact with each other and created a complex picture for language learning in this context.

Reference

Snow, C. E. (1983). Literacy and language: Relationship during the preschool years. *Harvard Educational Review*, 53, 165–189.

■ Portrait of a Spanish Native Language Head Start Classroom

Consuelo Aceves

If research on English-language learners' language development and coping strategies in English-medium preschool classroom settings is inadequate, even less is known about what can occur in preschool classroom settings where the native language is supported and further developed. In the 1970s, one study examined the impact of Spanish native language and instruction in English as a second language and found that bilingual preschool curricula contributed to the positive language development of children in Spanish and English (Juarez and Associates, 1980). In order to add to the limited information on this topic, a descriptive study examining teacher beliefs and language practices in a Spanish native language 3-year-old Head Start classroom was developed.

The classroom was visited every 2 weeks for 1 school year. Both teachers in the classroom were bilingual Latinas and the dominant language of the classroom was Spanish. The 16 children were all Latino; some spoke English as well as Spanish at home. Interviews were conducted with the teachers regarding their beliefs about effective early childhood teaching, language diversity, and Spanish language use. Classroom observations were conducted to

capture the language learning opportunities and to understand the general context of the learning environment. The questions addressed in this study are: (a) What are the teachers' attitudes and beliefs about language practices in this Head Start classroom with bilingual children? and (b) How do the teachers support children's language development in the classroom?

In interviews with the teachers, they stressed: (a) the importance of using the children's native language for instructional and interactive purposes in a context of respect and affection, (b) the need for positive teacher attitudes towards bilingual children, and (c) the significance of creating "cultural continuities" between home and school. In practice, teachers created a "culturally congruent" environment with traditional Latino sociocultural values as defined by education (Goldenberg & Gallimore, 1995). Shared values (respect and affection) and shared language (Spanish) form two cultural continuities between teachers and children and home and school. Teachers attributed the children's academic, social, and self-expression to their willingness to use Spanish.

Furthermore, teachers supported the children's language development through specific teaching practices. During story time, teachers read English books translated into Spanish and then asked the children to answer questions and to retell the stories giving them opportunities to express their knowledge. In addition, teachers extended the children's language by providing additional information, rephrasing, and asking for clarification from them. Consequently, children became more expressive. Children were using sophisticated vocabulary in the context of classroom activities and were speaking far more than would be possible if they had been functioning in an English-speaking classroom. These findings will be discussed in terms of effective native language instructional practices and language development of bilingual children in preschool.

References

Goldenberg, C., & Gallimore, R. (1995). Immigrant Latino parents' values and belief about their children's education: Continuities and discontinuities across cultures and generations. *Advances in Motivation and Achievement, 9*, 183–228.

Juarez & Associates. (1980). *Final report of an evaluation of the Head Start bilingual/bicultural curriculum models*. Washington, DC: U.S. Department of Health and Human Services.

■ Portrait of an English Language Head Start Classroom Serving Children From a Variety of First Language Backgrounds

Anne Wolf

Despite increasing numbers of children in Head Start who speak languages other than English, bilingual[1] children often find themselves in classrooms where English is the only language spoken. Just as these children are confronted by an unfamiliar language and the difficult task of learning English, their teachers face the challenge of teaching children with whom they do not share a language.

To help understand how Head Start meets the needs of children from diverse language backgrounds, a descriptive study of the language-learning environment in one English-language Head Start classroom, in which 70% of the children spoke languages other than English and the teachers were monolingual English-speakers, was presented. Over the course of 1½ years,

[1] In this symposium, the term "bilingual" is used to designate a child or adult who is exposed to at least two languages on a daily basis.

extensive observational, interview, and linguistic information was gathered through weekly classroom visits. Based on these data, characterizations were made on how the teachers communicated, organized the classroom, and used the curriculum to support bilingual children, as well as how bilingual children functioned in the classroom.

Although the teachers spoke English almost exclusively, they employed many means to help children communicate successfully. The teachers used nonverbal strategies to facilitate children's understanding of English. They verbally recast and expanded children's nonverbal and, later, verbal attempts at communication. The teachers encouraged children who were beginning to learn English to practice using it, first, by giving children the needed words and, later, by asking children to produce such words themselves. These strategies worked together to provide bilingual children with exposure to the new language and with the comfort to risk trying to communicate, first, nonverbally and, later, in English.

Several aspects of the classroom organization, including the physical setup, consistent daily routine, peer guidance, and small-group activities, provided both social and linguistic support for bilingual children. This facilitated bilingual children's participation in classroom activities, eased their ability to negotiate social interactions, and, in doing so, created more comfortable opportunities for language learning.

Although the teachers provided a great deal of social, communicative, and linguistic support, there were some notable limitations of the English-language curriculum for bilingual children's social functioning and linguistic development. Bilingual children encountered some painful and frustrating experiences as a result of the English-only curriculum; they rarely found support or social acceptance, even from peers who shared the same home language. Using English exclusively communicated an implicit message about the negative value of speaking languages other than English in the classroom, which seemed to contribute to bilingual children's socially marginal status. Although incorporating children's home languages into the classroom presents a difficult challenge for teachers who are monolingual English-speakers, strategies for doing so will be explored.

Methods, Measures, and Assessment

Ethnographic and Other Qualitative Methods in Research on Child Development and Early Childhood Programs

CHAIR: Carol L. McAllister
DISCUSSANT: Robert Emde
PRESENTERS: Carol L. McAllister, Holly Kreider, Kimberly Friedman, Jean Ann Summers

Ethnography is a qualitative methodology that historically has been associated with the discipline of anthropology and the study of small-scale societies outside the United States and Western Europe. Increasingly, however, ethnographic and related forms of qualitative inquiry are being used to understand American society and to explore pressing social issues such as poverty, racism, infant mortality, school failure, and community violence. At the same time, studies of human service programs designed to address such issues have begun to give more attention to qualitative, and in particular ethnographic, methods as a component of program evaluation and policy analysis. This includes research with early childhood programs, such as Head Start and Early Head Start as well as studies involving public schools.

In many cases, ethnographic approaches are combined with more conventional quantitative techniques with the goal of helping researchers and practitioners to: (a) contextualize and interpret statistical findings; (b) begin to explain "why" and not just "what;" (c) suggest new lines of inquiry and new research questions; and (d) explore areas of concern less amenable to purely quantitative approaches (for example, clients' own views of programs and policies, the meaning of various experiences in the lives of program participants, and the influence of culture on policy implementation and outcomes).

The symposium explored the new use of ethnographic and mixed-method inquiry through reports from three current research projects. The first study is an evaluation of an Early Head Start program in Pittsburgh, PA, that employs a number of ethnographic methods (e.g., family case studies, participant observation of program activities, and mapping of community contexts) to examine parenting beliefs and practices, program interventions, and the impact of recent policy changes on both. The second research project is the multisite Comprehensive Child Development Project (CCDP) Follow-Up Study by the MacArthur Network on Successful Pathways through Middle Childhood whose central design is a mixed-method inquiry including a series of integrated school/community/family/child case studies. The third project is a comparative examination of ethnographic and quantitative findings concerning family risk and resiliency among Early Head Start program participants in Kansas City, KS. The basic methods of ethnographic and related forms of qualitative research and their application to the study of child development and early childhood programs were introduced. Similarities and differences among the three studies provide insights into the possibilities of ethnographic and mixed-method research as well as highlight the value of such approaches for program development and evaluation.

■ Parenting, Policy Changes, and Programs for Infants and Toddlers: Ethnographic Approaches in the Evaluation of Early Head Start

Carol McAllister, Laurie Mulvey, Beth L. Green, James Butler

PRESENTER: Carol McAllister

The core of ethnographic research consists of a dialectical movement between "listening" to people's everyday lived experiences and providing analysis and interpretation to "make sense" of these experiences and participants' own understandings of them. A critical aspect of this "dialectical dance" is the discovery of the right questions—both the questions to ask our "informants" and the questions to ask ourselves as researchers. This approach has been crucial in our work with the Pittsburgh EHS program where we are attempting to describe and explain several variables: (a) families' own views of parenting and child development (what we might call "parental ethnotheories," Harkness & Super, 1996); (b) the impact of public policy changes such as welfare reform on parental beliefs and practices; and (c) the way the EHS program itself intervenes in this process to promote and support positive parenting and child development.

Drawing examples from our local EHS research, the presentation reviewed the basic building blocks of ethnographic methodology, with emphasis on the continuous and iterative nature of data collection and data analysis and the opportunities this, in turn, provides for an effective integration of ethnographic inquiry with more quantitative research methods. For example, our experience demonstrates the usefulness of ethnography for contextualizing key findings produced through structured interviews and for "unpacking" process mechanisms (i.e., the "how" and "why" of social behavior). This approach has been helpful in our attempts to understand why some families fail to seek parenting support from the EHS program, and how both families and staff understand the relationship between the demands of welfare reform and effective parenting. Such clarification is beneficial not only for researchers but also for program practitioners and policymakers.

Our ongoing efforts to employ a mixed-method strategy in our evaluation of the Pittsburgh EHS program highlights the value of ethnographic research in identifying emergent factors and connections that might not have been treated as variables or hypotheses in the original evaluation design. In addition, an ethnographic approach consistently guides our attention to cultural contexts and processes. This includes an elicitation of the viewpoints of various study participants (i.e., families, program staff, and policy makers), and an elucidation of the points of convergence and divergence in their understandings of key matters such as "good" parenting, program "support," and welfare "reform."sIn sum, ethnography provides an opportunity for thick description and thus the exploration of the meanings that underlie human behavior. This is particularly crucial in research focused on the complex mutual interactions among a child's development, parenting beliefs and practices, program interventions, and the broader public policy environment.

Reference

Harkness, S., & Super, C. M. (Eds). (1996). Parents' cultural belief systems: Their origins, expressions, and consequences. New York: The Guilford Press.

■ A Mixed-Method Approach to Understanding Family-School Communication

Heather Weiss, Jane Dirks, Kim Friedman, Gisella Hanley, Holly Kreider, Eliot Levine, Ellen Mayer, Carol McAllister, Margaret Vaughan, Jane Wellenkamp

PRESENTERS: Kim Friedman, Holly Kreider

Child development researchers are increasingly recognizing the value of mixed-method approaches for capitalizing on the strengths of diverse frameworks for social inquiry. By thoughtfully integrating quantitative and qualitative methods, for example, we can transcend paradigmatic boundaries and generate complementary and mutually informative sources of knowledge (Greene & Caracelli, 1997). The presentation described the mixed-method strategy adopted in the MacArthur Comprehensive Child Development Project (CCDP) Follow-up Study, focusing on the contribution of ethnographic inquiry to the overall research process.

The aim of the study is to expand understanding of children's developmental trajectories as they traverse the elementary school years. The study is accomplishing this through longitudinal research with approximately 400 children, their families, schools, and communities. The study relies on a variety of quantitative measures as well as in-depth ethnographic case studies with 23 children, their families, and their schools. The presentation focused specifically on the role of family-school communication in shaping children's trajectories.

Through three case study vignettes that illustrate different aspects of family-school communication, the presentation demonstrated how ethnographic inquiry has deepened our understanding and added complexity to prior conceptions of family-school communication as initially measured in quantitative work. One quantitative finding is that nearly all parents attend parent-teacher conferences, suggesting a great deal of family-school communication. However, our ethnographic work suggests some problems with this interpretation. Our first vignette illustrates how there can be many missed opportunities for constructive communication between family and school during parent-teacher conferences. Likewise, school-based team meetings that address individual children's problems suggest intensive collaborative intervention in children's learning and behavior problems. However, the second vignette deepens our understanding of these communication events by illustrating how one parent felt overlooked and intimidated by the school in its efforts to address her child's behavior. Finally, our quantitative results indicate that informal conversations between parents and teachers are the most frequent form of home-school communication reported by teachers. The third vignette illustrates the complexities of this under-examined phenomenon that affects one child's success.

These initial ethnographic findings informed the development of later quantitative measures in ways that move beyond traditional categories of home-school communication. The thoughtful addition of ethnography to a quantitative approach can deepen current conceptions of education issues and better inform policy recommendations. Our use of mixed methods to explore family-school communication suggests that parent-teacher conferences and other formal school meetings can be better utilized and that informal patterns of family-school communication also can be capitalized on to promote children's successful pathways through elementary school.

References

Greene, J. C., & Caracelli, V. J. (Eds.). (1997). Advances in mixed-method evaluation: The challenges and benefits of integrating diverse paradigms. *New Directions for Evaluation, No. 74*. San Francisco: Jossey-Bass.

■ Perspectives on Risk and Resilience: Comparing Quantitative and Ethnographic Methods

Jean Ann Summers, Jane Atwater, Judith Carta, Mary Grace Brown

PRESENTER: Jean Ann Summers

This investigation explored how quantitative and ethnographic measures of families may both differ and converge in developing perspectives of family risk and protective factors. The study used the Early Head Start program outcomes as an organizing framework for understanding risk and protective factors which might be indicated by either methodology. Interview transcripts from the ethnographic study for 13 families were coded and scored to identify whether the family appeared to have either strengths or weaknesses in each of 18 program family outcomes. Using measures from the quantitative study intended to approximate these outcomes, individual scores for the same 13 families were also used to rate the family as having strengths or weaknesses in those outcomes. The scores derived from each methodology were compared in each of three broad program outcome areas (parent-child outcomes, self-sufficiency outcomes, and family support/mental health outcomes) to identify agreements and disagreements. Interpretations of discrepancies and similarities between the two methods were discussed.

Understanding the Nature of the Intervention Process in Home Visiting Programs: Approaches, Measures, and Methods

CHAIR: Beth L. Green
DISCUSSANT: David Olds
PRESENTERS: Susan McBride, Carla Peterson, Kathleen Hebbeler, Beth L. Green

This symposium presented research that illustrates innovative approaches to understanding the intervention process in early childhood home-visiting programs. Many aspects of home-visiting interventions remain a "black box" from both a programmatic and a research perspective, and there is still relatively little research that focuses on understanding the specific aspects of services that may lead (or fail to lead) to outcomes for children and families. Such research represents a critical intersection between research and practice and requires close collaboration and trust between the members of these two groups, an approach that is reflected in the presentations. Several different approaches to understanding and documenting the home visiting process were presented.

First, McBride and Peterson introduced an observational method for documenting the nature and content of interactions between parents, children, and staff during home visits conducted in an Early Head Start program. Trained coders observed home visits conducted by two groups of staff: child development specialists who provide parenting and child development services and family development specialists who provide adult and family services and support. Additionally, information was collected through staff self-report about the nature and content of the home visit. Contrasts between the two methods suggest that there are numerous discrepancies between the ratings made by observers and staff's self-report. The data suggest the need to understand the nature of these differences in the perceptions of the home visits.

Second, Hebbler and Gerlach-Downie combined qualitative and quantitative methods to assess the relationship between actual program intervention and outcomes in a Parents as Teachers (PAT) program. Drawing from multiple sources of data, including focus groups, longitudinal case studies, videotaped home visits, and parent questionnaires, themes and patterns in the data suggested that although parents viewed PAT as beneficial, parents did not believe that the program changed their parenting behavior. Analysis of the home-visiting information suggested that home visits were characterized by a focus on emotional support and helping parents feel good about parenting, rather than on behavior change. The study raises important issues about how various stakeholders view the role of the home visitor and how this view may influence program outcomes.

Last, a multimethod approach to understanding whether services are delivered in ways consistent with a family-centered, strengths-based philosophy of practice was described. Three parallel sets of measures based on eight key principles of strengths-based practice were described, including a parent self-report, a staff self-assessment, and an observational rating. The collaborative process used to develop these measures will be described, and psychometric data from each method will be presented. Parents' ratings of staff across the 8 principles tend to be highly correlated, while both staff self-assessments and observational methods are more sensitive to differences across the 8 subscales. However, parent self-report does discriminate between programs that do and do not espouse a strengths-based philosophy. The usefulness of these tools for both research and practice will be discussed.

Each of these studies represents a significant step toward developing methods and measures that can be used to better understand the nature of home-visiting programs. Two key issues are highlighted in the studies. First, all presentations suggest the importance of multiple sources of data in order to fully describe the nature of the home visit. Second, they all suggest that stated

program philosophies or goals are not necessarily reflected in the actual service delivery process, underscoring the need to document the home-visiting process in order to understand program outcomes.

■ Home Visit Observations: What Do They Tell Us?

Susan L. McBride, Carla Peterson

Despite pervasive use of home visiting as a model of service delivery for prevention and intervention efforts with young children and their families, the actual nature and content of home visits have rarely been documented. Researchers often assume home visiting is provided by program staff and received by families in a homogenous manner. Recently, Guralnick (1997) has suggested that we need "second generation" research that investigates how specific aspects of interventions are associated with outcomes. New methodologies are necessary for documenting how specific interventions used during home visits are associated with various family and child outcomes.

Efforts were made to document various aspects of home visits being provided in two different home visiting programs in central Iowa: one serving families of children with disabilities (Part C) and the other an Early Head Start program. The primary objective of the study was to describe the nature and content of the home visit intervention.

Data were collected using the Home Visit Observation Form. This partial interval observation system requires the observer to code (a) primary interactors (e.g., parent and child or parent and interventionist), (b) content of the interaction (child development, child health and safety, family functioning, etc.), and (c) nature of the home interventionist's role (observing, asking or giving information, supporting parent-child interaction, etc.) every 30 seconds. Data are collapsed across intervals to indicate the percentage of time each category of behavior occurred during visits.

Findings to date indicate that in Part C programs, the interventionist is more likely to be interacting with the child; over 80% of the time interactions are related to the child's development and over 50% of the time, the interventionist is teaching the child directly. In EHS, the content and process of home visits are related to the role of the home interventionist. That is, child development specialists (CDS) are more likely to address child development issues while family development specialists (FDS) focus on family issues such as relationships, employment, or education. Both the CDS and FDS primarily support interactions with parents or other adults (over 50% of the time). In both studies, the amount of time devoted to supporting parent-child interaction by modeling or coaching parent-child interactions was limited (less than 1% in Part C and 16% in EHS). In summary, the process and content of home visits appear to be related to assumed program goals and training of the interventionists. Further analyses will focus on the extent to which the intervention process varies based on the characteristics of families or children. Eventually, the relationships between intervention variables and family and child outcomes will be explored.

Reference

Guralnick, M. J. (Ed.). (1997). *The effectiveness of early intervention.* Baltimore, MD: Paul Brookes Publishing.

■ A Case of Misguided Theory: Why Home Visiting Did Not Prevent Poor Development

Suzanne Gerlach-Downie, Kathleen Hebbeler

Previous research has focused on the effectiveness of home visiting without exploring how this strategy operates. This study used qualitative techniques to conduct an in-depth exploration of the nature of the intervention in a home visiting program over a 3-year period. The perspectives of the primary participants—the parents and the home visitors—were of interest, as were the dialogues and activities that took place during actual home visits. The "black box" of home visiting for this program was specified and its relationship to child outcomes examined.

The program studied was a Parents as Teachers home visiting program implemented in a rural, predominantly Hispanic farming community. Findings were derived from focus group discussions with participating parents and home visitors, longitudinal case studies of 21 program families, and data collected for a companion quantitative study. Thirteen case study mothers were Hispanic. Eight of the 21 were under 20 years of age at the time of enrollment. Case study data included interviews with parents and home visitors and videotapes of home visits. The quantitative study provided data on the home environment and child development as assessed by the Developmental Profile II and the Bayley Scales of Infant Development.

Several findings about the nature of the intervention were confirmed across the various data sources. The home visitors saw their role as providing information and helping the parents believe they were good parents who would act responsibly, given appropriate information. The home visitors used the words "validation" and "empowerment" to describe what they were trying to do for parents. The home visitors did not view their role as changing behavior. Home visitors placed little pressure on parents to change their parenting behavior and rarely asked about their parenting practices.

Parents were very positive about their participation in the program. They said it helped them be aware of their child's development, feel good about their parenting, and confident that home visitors could detect developmental delays. However, after 3 years of involvement, most parents felt the program did not cause them to significantly change their views about parenting.

By 3 years of age, some children were showing poor developmental outcomes but the home visitors reported that each child was doing well. Parents also reported that their home visitor had reassured them that their child was developing well.

The qualitative methods used in this study were effective in elucidating the hypothesized mechanisms through which this particular home visiting program was to improve child development. The methods were equally effective, especially in combination with the data from the child assessments, in identifying the shortcomings of this theory. Providing information and helping parents feel good about themselves is not sufficient to promote optimal child development. Policy makers and program developers need to articulate the "black box" of interventions and examine how they are carried out. The study raises questions of how home visiting programs can be sensitive to diverse families while helping parents promote child development.

■ Family-Centered Principles of Practice: Are They Really Being Implemented?

Beth L. Green, Carol A. McAllister

Since the 1980s, models of service delivery based on a "family-centered/strengths-based" philosophy of practice have become increasingly popular (Dunst, Trivette, & Deal, 1994; Kagan & Weissbourd, 1994). However, there is still little research focusing either on whether services are actually being delivered in ways that are consistent with this service philosophy or whether adopting this approach leads to more positive outcomes (Powell, 1987). Developing measures that can be used to assess implementation of strengths-based services, therefore, is critical to furthering our understanding of the intervention process. The development of a multi-informant approach to measuring the implementation of family-centered/strengths-based principles of practice in home-visits was discussed. Three instruments are being developed: (a) a staff self-assessment, (b) a staff observation (completed by supervisors), and (c) a parent self-report questionnaire.

Staff Self-Assessment. Staff working for an Early Head Start (EHS) program rated themselves on a 5-point scale in terms of the frequency of specific behavior towards families during the past month. Survey items tapped 8 domains of family-centered practice: (a) strengths-orientation, (b) family-driven, (c) individualization, (d) equal partnership, (e) cultural competence, (f) community-oriented, (g) relationship-building within families; and (h) relationship-building between families.

Observational Assessment. Each staff member was observed during a typical day by his or her direct supervisor. Supervisors were trained to use the observational instrument to describe the extent to which family-centered practices could be observed. The instrument consists of items paralleling the 8 principles assessed in the staff survey. Supervisors rated (on a 5-point scale) the frequency of specific staff behaviors during the home visit. Trained research coders also rated a series of home visits.

Results. In both self-assessment and observational ratings, staff in different job categories were rated differently on the 8 subscales. Case management staff scored higher on principles related to collaboration with agencies and goal setting, while child development staff scored highly on principles related to parent-child interaction and relationship building. Further, while staff self-assessments and observations were generally similar, staff tended to rate themselves less positively in general across all subscales. Follow-up observations of home visits made by the research staff suggest that supervisor ratings may have been upwardly biased.

Parent Self-Report Survey and Results. A questionnaire was designed to assess families' perceptions of staff behavior. The questionnaire consists of 40 questions assessing the 8 components of strengths-based practice. Fifty-three parents who reported participating in Healthy Start, Early Head Start/Family Resource Centers, or Child Protective Services were interviewed.

The results suggest that the scale discriminates between providers: EHS/Family Resource providers were rated as more consistent with the family-centered model of practice. Follow-up data on EHS families suggest that the scale may have problems with ceiling effects. Further, the 8 subscales were highly correlated with each other, suggesting that parents may not discriminate well in their ratings of staff (e.g., halo effects).

These data represent a first step in an ongoing effort to develop instruments that can be used to assess the implementation of family-centered practice. Ultimately, such data will allow us to better understand the characteristics of home visits that are most importantly linked to outcomes.

References

Dunst, C. J., Trivette, C. M., & Deal, A. G. (1994). *Supporting and strengthening families: Methods, strategies, and practices.* Cambridge, MA: Brookline Books.

Guralnick, M. (1997). *The Effectiveness of early intervention.* Baltimore, MD: Paul H. Brooks.
Kagan, S. L. (1994). *Defining and achieving quality in family support.* In S. L. Kagan & B.
Weissbourd (Eds.), *Putting families first: America's family support movement and the challenge of change* (p. 375–400). San Francisco: Jossey-Bass.
Powell, D. (1987). Methodological and conceptual issues in research. In S. L. Kagan, D. R. Powell, B. Weissbourd, & E. Zigler (Eds). *American's family support programs: Perspectives and prospects* (p. 311–328). New Haven, CT: Yale University Press.

David Olds: It is a pleasure for me to discuss these papers because this is the kind of work that needs to go on in our field. We need to understand the internal workings of these kinds of programs. I realized when I heard the papers today and read parts of them that I do not have much to add because what I have to say has already been said in one way or another. However, there are a few things that I would like to emphasize.

First, what is so exciting about this set of papers is the multiplicity of methods that are being used to examine process. We are looking at in-depth case studies and quantitative indications of program implementation, in a visit-by-visit basis in some cases. We are also looking at observations of the home visit and coding those observations in a time sampling way. This is phenomenal. This kind of work will eventually lead to an improvement in both the design and implementation of good home visiting programs. Particularly important to note is that, as Kathy Hebbler said, there was reluctance on the part of the home visitors to think seriously about behavioral change. For me, this is a very critical issue in the home visiting arena.

I have seen this for several decades. We reviewed some literature a few years ago on home visiting programs that began during pregnancy, on early childhood programs, and so forth. It struck me that many of the early programs, both in the US and Britain, were designed to improve pregnancy outcomes. Their approach, though, was to improve pregnancy outcomes by helping women feel better about themselves, based on the assumption that if they have less stress, they feel better about themselves and the outcomes of pregnancy will be improved. They chose explicitly not to alter behaviors like prenatal smoking, diet, and so forth, because somehow that would be viewed as too intrusive and inconsistent with this philosophy of general support that families need. This theoretical and philosophical orientation to home visiting produced no effects on pregnancy outcomes.

We need to be careful about moving to the other extreme. Recently, our program was highlighted in a front-page article in the Washington Post entitled, "Strictly Speaking, Success." According to the article, the reason that this home visitation program by nurses that we have developed has produced effects where others have not, is because the nurses go into homes and tell women to not have any more babies, stop smoking, and use condoms. The reason that program has been so successful is because nurses tell families what is desirable behavior. However, the danger, of course, is that we are not in the business of telling people what to do or intruding in families' lives, which is exactly the concern that has led many home visiting programs to philosophically avoid that kind of stance. We need to be very concerned about that kind of an approach because it does not work to simply go in and give families what-for.

It is also not enough to simply be supportive. We have got to find a way of being clear about what we are trying to accomplish. We need to have good theories of behavioral change that are both respectful and family-centered, and, at the same time, pay attention to the behaviors we want to affect because there is good evidence to indicate that those behaviors can either promote or damage the health and development of children. That leads us back to the prior concern that I have heard through all the talks—we need to have good theory—microtheory as Kathy said—about both what we are trying to accomplish and how we expect to get there. We need a more carefully articulated conception of what we are trying to accomplish, how we think we can get there, and what clinical methods can bring about behavioral and contextual change.

In the process of examining programs with this kind of depth, we will gradually learn how to do this work more effectively.

One of my concerns about the field of research in this area has to do with deciding at what point do we do this kind of work. Do we do it after we have initiated a randomized trial? No, I think that this is work that needs to be done up front. Do we want to test that program, given the current strategies that are being employed? Maybe there is some value in that. As the Comprehensive Child Development Program (CCDP) evaluation showed, we are paying a tremendous societal cost, because we continue to test programs that have not been well worked out theoretically, conceptually, empirically, and clinically in advance. The results then have negative consequences for children's programs in the media and on Capitol Hill. If one looks at the list of randomized trials that have been conducted in this area, many, if not most programs have not been adequately developed clinically and theoretically before testing. This kind of work is incredibly important. My only comment is we need to do it sooner, before we put the programs to test.

AUDIENCE COMMENTS AND QUESTIONS

Question: We keep trying to promote child development through home visiting. Home visiting does not seem to be intensive enough to impact child development. It makes me concerned for Early Head Start and the screening that is going to be given to us, which will look at IQ from home-based-only programs.

Comment: We have not developed and implemented a program sufficiently to be able to measure child development outcomes, but it does not mean that we cannot or that we should not.

Comment: Additionally, if we think parent and child interaction is where it is at, we have not tried targeting that in home visiting. Do the Denver trials data involve a parent/child interaction measure?

David Olds: The implementation data that we have on the Denver trial show, among other things, that nurses and paraprofessionals differ in the quantity of home visitation. Nurses are able to complete a larger number of home visits in the first 2 years of the child's life, and they are spending a lot more time on the visits on a domain that we call Promoting the Maternal Role or Paternal Role. The difference comes from the impression that the paraprofessional visitors feel less comfortable teaching and less comfortable promoting behavioral change, in spite of the fact that that is part of the program protocol. They are doing it, but they are spending less time on it. Yes, we are looking in-depth at qualities of diadic interaction using home observations, observations on videotape, interactions in a laboratory, and so forth.

I would like to point out that we have not had treatment main effects on IQ in the study. We have improved qualities of home environments and qualities of diadic interaction in our studies in the past, and we reported on the effects in one of the articles reported in the Journal of the American Medical Association in the summer of 1997. We found effects on the infants' responsiveness and communicativeness interaction with their parents in the Encast treatment observation.

We have seen effects on children's long-term social adaptation reflected in things like arrests, convictions, and probation violations. However, we do not see effects on traditional IQ or academic achievement outcomes. My guess is that center-based programs are better at affecting those aspects of development, in part because they have more time with children to focus on those domains. That does not mean, though, that what goes on during home visits cannot be enormously important. It can. It just means that there are different aspects of the child's health

and development in family functioning that may be more legitimately affected through home visitation services.

Hebbeler: You do not have to conclude from our study that intensity is the issue. One could conclude just as easily that the time they had was not used as effectively as it could have been. Had that time been used differently, the intensity might have been enough. It is not necessarily the intensity that is the culprit here.

Comment: Is it not the case that there have been evaluations of the Parents As Teachers program that have showed differences in children's school achievement?

Panelist: The findings from the quantitative study have not been released so I cannot tell you what they show. There have been other evaluations of PAT, many of which are methodologically weak.

Comment: I am interested in the issue of paraprofessionals and what characteristics that paraprofessionals possess that have an influence on their effectiveness.

Olds: There is a theory about why paraprofessionals might do a better job than professionals in this area. Reduced social distance is likely to lead to greater empathy and understanding of the family situation on the part of the home visitor and a greater feeling on the part of the family members that paraprofessionals are going to truly understand them, speak their language, and share their views. The result is better relationships and perhaps better role-modeling effects.

We also need to understand that just as there is tremendous variation in the nature of home visiting programs themselves, there is tremendous variation in paraprofessionals. In the study we conducted, we focused on paraprofessionals who are from the community, meaning that they have no more than a high school education. Almost all of them have personally received public assistance in the past. They do not have any advanced training in nursing, psychology, social work, or education. They need to have met some minimal requirement for entry into the workforce, but have no advanced training,

We have done that because many programs around the country have been based on the model that this was an opportunity for us to create employment for women in low-income communities. We felt that as we started to carve out an understanding of this field, it would probably make sense to start at the extremes of this continuum with that type of home visitor on the one hand and prepared nurses on the other. There is one thing that I wanted to point out with respect to Peterson and McBride's paper. I know that they are going to be moving in this direction, and I am thrilled to see the comparison of programs that has been done to help us understand, again, how these programs differ. We also know though that there is tremendous variation within those programs. There is variation within individual families or within families at different points in time, and there will be tremendous variation in content and in methods among families within the programs.

A good example of this is if we think about the relationship that exists between the home visitor and the mother and where there is a behavioral change focus. We found that nurses over time become more comfortable as they feel like the relationship has developed by expecting higher levels of effort on the mother's part to take charge of her life or to deal with issues regarding her child. We find when we look at qualitative work in our case that the nurses will constantly be thinking, "how hard can I push her right now?" Over time there seems to be greater willingness as the relationship deepens to take a chance on pushing harder. This is an example of how things change by time.

Panelist: Here is the sad news. Do not take it for the real thing yet, but the Early Head Start data is based on at least 201 home visits. They are divided into what we called Time One, which is the first 6 months of the service with the family, Time Two which is the second 6 months of service with the family, and Time Three which is the third 6 months of service with the family. It was thought that the nature of their relationship and what they did over time would change the mean values. However, the mean values are not changing. We then said, "Let us look within families, because it could be that different families might be getting different kinds of things." We have not found differences within families and it is very discouraging.

Comment: When talking about the outcomes of research, we have to consider the training of the home visitors and whether they are paraprofessionals and have ongoing supervision.

Comment: There are none. Historically, home-based services have had a difficult time delivering quality services. Yet we do have some outcomes from our research which validate the importance of this system. Early Head Start, at least the programs with which I am personally familiar, has had problems with supervision, management, and training. We have the most qualified, graduate degree home visitors, but we have an ongoing supervision problem.

Beth Green: When we started our project, the program director said, "If nothing else, having supervisors do this will get them to go into the home and look at a home visit," which they had talked about doing during the 5 years of CCDP and had never done. There is great reluctance on the part of supervisors to go in and actually look at what is happening. That is unusual.

Comment: I also think that paraprofessionals do not have the professional training nor the ongoing support to deal with difficult situations.

Comment: Home visits, if they have not increased the child's developmental outcomes, have cut down on abuse and neglect.

Olds: We need to be very clear about this. There are in fact very few programs that have produced that kind of an effect. The truth is that the only study that I am aware of that has solid scientific evidence that we can reduce the rates of child abuse and neglect is the one that my colleagues and I conducted. Just as there have been many claims made about all kinds of home visitation programs, if you look at the carefully conducted randomized trials, the only one that has shown that was the original that my colleagues and I conducted in Elmira, New York. There is good indication from our Memphis replication that it produced reductions in injuries to children, which look like a reduction in child abuse and neglect.

We need to be careful about generalizing about home visitation services and what they can and cannot do. What do these programs do to produce the reduction in child abuse and neglect? I am increasingly convinced that the prenatal inception, in our case, of home visitation adds a lot to the power of the program by reducing things like subtle neurological impairment in the newborn. We need to be very careful about overgeneralizing findings.

Comment: In looking at Project Home, in essence it seems that you are comparing apples and oranges. You were comparing a program whose purpose was to focus on the child with a program that seemed to have a much more family-oriented approach, and therefore did not have as much child-direct interaction. It was, however, looking at families comprehensively and addressing more issues than the former one did.

Comment: In fact, in Part H, we did some interviews with home-visitors, and they thought they were participating in a very family-centered type of program, so they were providing support to

families, such as information about community resources, and so forth. At that point in time, they were talking the talk, but not walking the walk. They are two different types of programs. It is interesting that they have two different profiles of what is going on. A theory of change for an interventionist directly working with the child 50% of the time, was that I, as a person going in once a week, could make a difference with a child by interacting directly with him or her. Obviously, that is not the case. That theory of change and the Early Head Start theory of change are two different kinds of theories and neither are sufficient.

Question: I come from a state that has state-funded Early Head Start programs in addition to federally-funded Early Head Start programs. From your perspective as researchers, where would we turn to look for research-driven models of the most effective forms of home visiting?

Beth Green: That is a very good question, and it is hard to answer for the very reason that David was talking about before: we have done a lot of outcome studies but not much on the intervention process. Does anyone have an answer for her?

Comment: The parent/child interaction theme has emerged very strongly. If the home visiting is not focusing on parent/child interaction but the goal is to change child outcome, then you are doing the wrong thing. At this point, I do not think the research can say: here is what has been proven; it can only say here are interesting things to look at when determining what kind of home-visiting model to use.

Carla Peterson: McBride and I have been struggling with people who say that they want to do one thing, but when we look at what they do, it does not appear to be the focus they claimed they wanted. My reaction is to be very clear conceptually about the desired program outcomes. Think about how to translate that into an intervention strategy and then think about ways to measure that effectively so that you have information to either go forward with what you are doing or change course and go in another direction. That fits with what you were saying about the need to have a well-conceptualized model or theory about change and then think about how we might make that happen.

Olds: I am concerned with the way that home visiting services generally are being oversold. We are doing ourselves a big disservice as a society in promoting programs that do not have a strong empirical foundation. We have chosen not to promote our particular program model because we wanted to wait. We have said the findings from our original trial were very promising, but we took the position that we ought not to disseminate it or replicate it programmatically because we wanted first to find out whether the findings would endure. Second, we wanted to know whether we could reproduce those findings with an African American sample in a large urban area. We have done that; we know that works.

We have begun a process of small-scale programmatic replication. We are moving toward the development of regional training centers based in schools of nursing and public health that will allow us to create the capacity for excellence in training, program implementation, and monitoring so we can have confidence in what goes into practice. It has a strong empirical foundation and also has a very strong foundation in clinical practice. One of the reasons we chose to hold off on this work was because we did not feel that we had the clinical features of the program adequately worked out. In fact, it has taken us 20 years. We now have detailed visit-by-visit protocols that guide nurses to work with families around particular targeted objectives throughout pregnancy and the first 2 years of the child's life. There is a corresponding integrated management information system that allows the visitors, families, and administrators of the programs to keep track of how things are going on an individual basis with families, nurses, and programs. Data is part of program management. That has been our strategy. People ask us all the

time if we share protocols or provide some light training or orientation and we say no because we want to work towards quality implementation and consistency with the model we have tested.

Comment: That would be the way to do it, but we are caught in a dilemma with Early Head Start. We need to look at the infant mental health literature and child development literature. We need to talk with Zero To Three to help us figure out how to get this information to Early Head Start programs.

Susan McDenna's interaction coaching material is something to consider. Jeannette McCullum at the University of Illinois has developed incredibly useful materials in terms of supporting parent/child interactions. They have not been empirically tested, but we are caught now. If we think that it is important, we need to pick up on what we know and what is developed and try it out.

Green: I would say to programs: Do not just adopt a curriculum and do it. Adopt a curriculum and then think about it and collect some information and reflect on what you are doing. Continue to be critical about what you are doing and assume that there is always room for improvement. Learn from other things that are going on.

Question: Are you expecting nurses and paraprofessionals to have the same behaviors?

Olds: Yes, we are expecting the same behaviors because the nurses and paraprofessionals have essentially the same program protocols to follow. The reason for that is because we know from the two previous trials that when the nurses followed those protocols, they produced beneficial effects. Frankly, our primary hypothesis has been that one of the reasons many of the paraprofessional programs tested to date have failed is because they have had inadequate theories about how to bring about change and inadequate clinical methods to guide home visitors in bringing about change.

We felt that we had protocols that were essentially well worked out with nurses. The difference, of course, is that there are issues of physical health that the paraprofessionals are unable to deal with as thoroughly as nurses, and we have made appropriate accommodation to the program model regarding that. Otherwise, they have exactly the same goals, objectives, methods, and protocols to follow as the nurses do.

Comment: By the same token, nurses may be at somewhat of a disadvantage in perhaps not understanding the community issues among families. One would imagine that any professional would have their own special take and talents, but there are deficits as well.

Olds: Absolutely. What you just stated was an elaboration of what I was saying earlier about why paraprofessionals ought to be able to do a good job. There is a theory about why they ought to do a good job if they are provided the right guidance. I would emphasize what someone else said earlier: If you do not have good clinical supervision, why bother? This is very complex work. When you are dealing with families who are experiencing many stressors, who have had many difficulties in their lives, and who are going to push the boundaries all the time, there needs to be good mental health and clinical supervision. If programs cannot provide that, it is a gross insufficiency.

Research in the Real World: Working Under Uncontrolled Conditions

"Conversation Hour" with Daryl Greenfield, David Cordray, Valerie E. Lee
CO-CHAIRS: John W. Hagen, Lonnie Sherrod

John Hagen: When one talks about research in real world settings, many things come to mind. Given my age and stage in my career, I think of Campbell and Stanley as a starting point. Some of the questions that we have had to deal with for a long time include: How important is it to have true control groups? How often can true experimental designs be achieved in real world research? How often do researchers use comparison groups?

In much of the work I have done, we have had various comparison groups, but not necessarily randomly assigned control groups. Other issues include the size of the study, for example the sample size, the scope of the study, and the kind of funding available. I have been working with the Society for Research in Child Development (SRCD) for many years. A few years ago we did a survey that looked at publication trends in our journal, *Child Development*. In our field, we like to think that we are broad and that we employ experimental methods. However, in the last few years, slightly under half of the studies published in *Child Development* employed a true experimental design, and there was a decline in studies of cognitive development. This is less so in the journal *Developmental Psychology*, which runs counter to some stereotypes.

The majority of the studies from the survey had samples of between 25 and 150. That tells us a number of things. First, there are few case studies or studies with samples under 25. Second, there are few studies that would qualify as sociological, that is, having samples in the hundreds or even thousands. Third, much of the research conducted in our field seems to be defined by certain parameters, which have changed over the last few decades. For example, studies from some of the disciplines that were prevalent in our field in the 1940s and 1950s, like anthropology, have almost disappeared, at least from our journals. Studies conducted by people in pediatrics have increased, although they are still small in absolute numbers. Lastly, in any kind of research in real world settings, there will be certain constraints. Yet, we still have to conduct solid research that will provide meaningful answers.

We convened a conference a few years ago entitled "East Meets West," where researchers from China, Japan, and Korea met with western researchers. We discovered some fundamental differences in the way we conceptualize constructs. For example, we discussed the role of fathers in child development. Western researchers have defined fathering in a quantitative way according to the number of hours per day or per week that the father and the young child are together. Eastern researchers thought that quantifying the construct did not reveal anything. Rather, the quality or the meaning of fathering was what was important. Sometimes it takes someone with a different approach to make us realize some of the limitations of our research.

Lonnie Sherrod: The Program Committee thought that the topic of conducting research in real world settings was particularly appropriate for a conference attempting to facilitate interaction between researchers and practitioners. I work for a private foundation that funds research. For us, interaction means three things. First, it means using research, including basic research, to inform the design of programs and policies. Second, it means facilitating applied research, that is, using programs and policies for children as a kind of naturally occurring context for the study of development. Whether the topic is social development or learning or attachment, we can conduct research on children in Head Start, for example, as a population for studying that topic. Third, interaction means designing and implementing scientifically rigorous evaluations of programs that include both analyses of implementation as well as an assessment of outcomes.

We have five questions to address, which emphasize the third kind of research/practitioner interaction: (a) What is the role of experimental design in evaluation research? (b) Much of

what we know about parenting and child development is based on nonexperimental correlational designs. What is the role in evaluation research of designs that examine correlations, for example, between program participation variables and outcomes? (c) How important is the substance or topic of the program to the evaluation design? Or is it a matter of one size fits all regarding the design? Does the evaluator need expertise in the area of the program? (d) What should be the balance between implementation type analyses to determine if the program is actually delivering what was intended versus outcome analyses in the evaluation? Should the same study and evaluator do both? and (e) There is frequently no relation between evaluation results and whether a program is sustained or not. How can we more effectively disseminate and use evaluation results?

David Cordray: I am very interested in the first question, because I think that the experimental perspective is critical. If we do not pay attention to it, then we run the risk of losing a very important source of control. Before talking about that, it is useful to articulate what we mean by uncontrolled. What is not controlled in these kinds of settings? It is useful to recognize, given what we have to contend with, the value of using an experimental type of paradigm.

First, we have very little control over the number of people that are willing to participate. It seems that every time you plan an intervention and estimate how many people will show up, 50% will leave as soon as the door is opened. That seems to be a fairly standard rule. Second, we do not have control over who participates, which is a serious concern for randomization. Third, we also have little control over the services people receive once they are enrolled in an intervention. Fourth and more importantly, we have little control over what people receive when they are involved in the "no-treatment" condition. We do not know how long participants are going to stay. There is often tremendous variation in participation levels and rates. Fifth, we do not know the circumstances under which they will receive various kinds of interventions. That is, they could be getting other interventions as well. That is a very short list to which we could add more. Of that long list of things that we cannot control, the majority occurs after the assignment to an intervention or comparison group. When thinking of the role of the experimental design, it seems silly to give away one source of control when we are going to have to contend with so many others. One of the major values of the randomization process is that it provides us with at least a head start, if you will, on trying to eliminate rival explanations due to uncontrolled factors that happen after the assignment process itself.

Daryl Greenfield: Part of the purpose of this symposium is to provide some diversity in perspectives. I am from an applied developmental psychology program in which we do a fair amount of work in communities with children. The program is part of a psychology department that trains its graduate students in traditional experimental design and statistics, but also exposes them to other approaches. Initially, we emphasize what good design is, but ultimately we focus strongly on the issues of partnership and working closely with people in the community.

If you have good partnership with the people you are working with in the community, you can, to some extent, overcome some of the issues that David Cordray addressed. We work with the Head Start program and the community schools and try to understand the questions they want to address, how we might answer those questions, and the best possible design to use. In some situations, a perfect design in which you can randomly control children to certain conditions and expect them to receive only that condition is not possible.

Valerie Lee: I am a faculty member in a school of education, and I conduct research using educational data. I consider myself to be a sociologist of education, whereas the overwhelming majority of participants at this conference are psychologists. So I bring a different perspective in several ways.

I would like to respond to what David Cordray said at the outset. Since there are many other

things we do not have control over, why should we give up the control we have over randomization? I would come at it the other way. Since we are going to end up with nonequivalent groups anyway, why should we try so hard to get equivalent groups in the first place when, in fact, it is so difficult to do so?

David Cordray and I might end up conducting a fairly similar study. Even using a rigorous experimental design with random assignment to one group or another, you might achieve randomization the day you actually do it, but lose it the very next day. Researchers have to take into account many other things and use statistical controls. Thus, you might have semi-equivalent groups, but not truly equivalent. I would argue that we should not worry so much about that at the first instance. I do a lot of secondary analyses, and I have never analyzed data with an experimental design. I am audacious enough to say that I do not waste a lot of effort in that direction.

However, we can improve nonexperimental designs. It is still important to have some kind of comparison in studies, particularly for addressing the question of program effectiveness. We have to think about what those comparison groups could look like. If we build into our designs longitudinal information and not just cross-sectional data, then we will have a much better situation for being able to make valid conclusions. We also need large sample sizes. I was shocked when John Hagen said the majority of the study samples were so small. The other drum that I beat is that in many educational programs, and I would characterize Head Start as one of these, a program is developed for a group of children, yet the overwhelming amount of the analyses never take that grouping into account in the methods employed.

Sherrod: Our second question deals with the fact that much of what we know in child development is, in fact, not based on experiments. Children are not randomly assigned to good versus bad parents, to poor versus good neighborhoods, to different kinds of family structure. Yet we think we understand something about how different kinds of parenting, different kinds of neighborhoods, and different family structures impact child development. On the other hand, many people, particularly policy makers, feel that an experiment is the only design that allows you to attribute causality to a program. If public funds are going to be spent on a program, policy makers want to make sure that it produces the outcomes in which they are interested. How do you prove causality with designs that are not experimental?

Lee: This is always a problem. We use causal methods to analyze data. I teach courses in this area, and I tell my students that they may want to dance around the issue of causality, but when you choose a dependent variable in a host of independent variables and find an arrow going in one direction, that is a causal analysis.

I might use the word effect instead of cause. If you have longitudinal research and know that "A" happened before "B," you have enormously increased your ability to say something about causality, even with nonexperimental designs. Longitudinal research is very important.

The amount of money available to conduct research is so important in terms of the design, where the sample is chosen, how large the sample is, and so forth, that I would argue that funding has driven us to such an extent that we start with small samples because we know we cannot get the money to study large samples. That has been very problematic.

Cordray: I am in a fair amount of agreement with what Valerie Lee has said. I think there are many ways to gather evidence about relationships and about causality. Our field thinks the strongest way is to have a tightly controlled experiment in which you are actually manipulating variables and have control over everything else. Those of us working in Head Start and in the community do not have that option. To argue that you can only draw conclusions if you have a strong causal relationship is a naive approach. We need to work as a community of researchers and support different kinds of research. We can collaborate across various sites and try to gather

data with similar sorts of measures that already have been used effectively. If we have a body of evidence that points in the direction of certain interventions being effective, we can draw causal relationships without actually having a single strong study.

Smoking is one example. Most of the evidence for smoking as a cause of cancer is not from randomized experimental studies, but rather from correlational data with very strong patterns of correlation that are replicated in different populations under different conditions. There is a dose-response relationship: People that smoke more are more likely to get cancer.

I am not arguing that we should just collect and analyze correlational data. We have models that tell us where to look, and we have models that tell us about mechanisms. We can also conduct animal research to examine some of the issues. Obviously we cannot study complex child development issues that way, but we can look at patterns.

Another example can be drawn from epidemiology. Epidemiologists have made contributions to changes in public policy before understanding the exact causal mechanisms. The classic example is the case of sailors getting scurvy. We did not understand what the mechanism was for that, but someone collected descriptive data and found that people that were not eating certain sorts of citrus were getting scurvy. That information alone led to a change in public policy.

There have been other examples in epidemiology in which the exact mechanism was not known, but the epidemiological data pointed towards changing certain types of behavior. Evidence was collected later to show what the mechanisms were. Although it is advantageous to have the mechanisms in advance, I would not stop doing the research because the mechanisms are unknown.

Lee: So far we are only talking about one kind of research: evaluation research that essentially poses the question, does that program work? There are other types of evaluation research, such as process evaluation, which we will discuss later.

Comment: Yesterday, Jack Shonkoff almost made a plea for less experimental designs. He talked about cancer research and said that if they had relied entirely on experimental designs they never would have found cures for cancer. However, cancer is very different than child development. I think what you are saying is that if people drop out of a study, we should just analyze the people who remain in the study. With cancer, we know that if patients did not receive treatment they are going to stay the same or get worse, whereas in child development, children grow with or without intervention. You cannot attribute gains in growth, even with the longitudinal data unless you have a comparison group. Some children are going to grow better even in the worst circumstances. To me, this cancer analogy is not that strong, and it argues more for having at least some sort of comparison or control group.

Cordray: Part of the problem with this discussion is that we are taking a cross-sectional look at what is essentially a process. The process, as I see it, is one that should continue. It probably is not identified as clearly to all of us as it should be. The process is that we could do an experiment, a good one or a poor one, and learn something from it. If we were to do a classic experiment, wait for the results, do the follow-up testing, and find out that there was or was not a difference, that would be a huge mistake. We would not learn very much from that. However, that is not what we do.

I spend a fair amount of time exploring different areas to see the kinds of research that is being done. Much of the good research being conducted is programmatic. It begins with an assessment of the problem and then proceeds to a preliminary attempt to address that problem by executing an experiment. Most of what we think are experiments probably are not truly experiments. They may come unglued fairly quickly. However, one does not explore the variability that develops as one proceeds. One needs to look at that variation and at the dose response within an experimental treatment and recognize that some people will decide that the program

does not meet their needs and leave early, while others will stay. One should examine the relationship between those receiving high versus low exposure, just as one does with the argument for the dose-response evidence in the cancer/smoking linkage. Everyone cautions about using dose-response data. Even though it is in the context of an experiment, it is nonexperimental data.

The second, third, or fourth step in this process is to recognize that one can intervene, yet again, by bolstering the intervention so that it takes into account the relationships that are found. If one finds that the more time spent in the home during a home-based intervention is related to outcomes, then one wants to know how much time it actually takes to instigate a change. Once one knows that, one should try to develop a model, a program, or an intervention that tests whether that is the causal determinant of the outcome. This process, in Campbell's evolutionary sort of epistemology, requires one to continue to hypothesize about the process and check it by intervening, and then to hypothesize again. Simply put, one needs interplay between the experimental and nonexperimental in interventions, where one explores the experiment in a qualitative-quantitative correlational way and uses the information to move forward to the next step. One should not think of this as correlational versus experimental research, but as a sequence of actions across time to try to identify what worked the last time as hypotheses and to check those hypotheses the next time around.

Sherrod: Does this mean that rather than asking, "Does the program work?" or "Does the program cause these outcomes?" we should ask, "What contribution does the program make to these outcomes?" That is much more like the question we ask in child development research. If, for example, a program explained 50% of the variance in an outcome, that would be very important, as opposed to a big group difference between the control and experiment group.

Cordray: You could answer that question by looking at the magnitude of the effect, even in a simple experiment.

Sherrod: But the issue is that to ask that question, you do not have to conduct the experiment, or do you?

Cordray: I think you are asking two questions. The first one is, did the program work? The answer to that may be no. However, the second question may be, are there some people that were differentially affected by the intervention? The answer to that may be yes. The problem is that we have a postassignment, self-selection bias that is possibly driving the differences between people who did and did not receive the intervention, even though it was offered to them. You are asking a more refined question while trying to be faithful to the original question. Your answer might be that the program was not implemented well or was only partially implemented and, thus, did not work well.

Sherrod: Would it be possible, however, particularly with large samples, to have a statistically significant difference between groups and still have the program account for an extremely small percentage of the variation in outcomes?

Cordray: You are talking about a much broader model. Within a study, there is an intervention and exogenous variables that relate to other developmental processes, which are not related by definition because this is an experiment. One can broaden the study to test multiple causes rather than testing one cause at a time. However, one isolates the cause that is policy-relevant.

We keep talking about large samples. To me, that is somewhat unfortunate. In preparation for this symposium, I reviewed several studies that are fairly influential, and the sample sizes for

some of these studies are what I consider small. That seems counter-intuitive, but it is not. Power is not a function of sample size. The most important contributor to power is the magnitude of the difference between the groups in the intervention. Given that we do not have real controls anymore, one could randomly assign to varying levels of intensity. These studies do not require large samples; they require large treatments.

Comment: My concern is that if a program is serving 100 children, and only 15 or 20 of those children are benefiting tremendously, an evaluation, correlational or otherwise, may not show significant results when the data are aggregated. Then the program loses its funding, and at what cost is it to those 15 children? I am not advocating for an inefficient allocation of resources, but sometimes we make decisions too quickly without asking how the program is working and for whom.

Greenfield: We do a lot of work with Head Start and the public schools, and they have the same orientation. They are not interested in, "Does the program work?" They try to understand what particular components might work best for what kinds of families under what conditions. They are interested in fine-tuning.

Head Start people believe that Head Start works. There is evidence that Head Start works. If we want to improve the program, we do not want to simply ask if it works. Given the diversity of the children and families that are served in Head Start, can we design interventions or components of interventions that target particular subgroups within Head Start? When you do a traditional "control group" experiment, any variation is considered noise and error as opposed to part of the program. Practitioners want researchers to understand that this is not noise and error to them, but rather real variation that they are trying to make sense out of on a daily basis.

In order to handle this, we have used nested longitudinal designs, which require large samples. We use hierarchical analyses in which we nest children from particular types of families or from particular classrooms where there is variation in the intervention. We must have a clear understanding of who is getting what treatment. The notion that everyone in the "treatment" group is receiving the same treatment and responding in the same way and that everyone in the control group is receiving the "treatment" and responding in the same way is naive in a real world setting.

It is impossible to have a situation where you design a strong intervention and one group is getting something wonderful and everyone else is not. Communities are trying to provide services to children and families. One cannot have a situation where there is huge diversity in the services provided. One has to measure the program content and dosage exactly, understand the variables that one thinks are important and measure them in the control group and in the "experiment" group, and then try to understand that variation and explain it.

Comment: We also need to recognize that any time there is a treatment, no two children ever receive the same treatment by virtue of the fact that the service is individualized. If this is recognized our research gains validity.

Cordray: It really is a matter of legitimacy in the interpretation. I do not disagree that we should identify those children who were differentially affected in a positive way by a Head Start intervention. However, one should not stop there. The next step is to identify backwards what kinds of features of the intervention seem to match those children. I would propose a matching study to determine the extent to which the hypothesized match that was identified actually does make a difference. It would be helpful to have data showing that not everybody was successful—that only 15 out of a 100 were. That is enough for me.

On the other hand, if one is wrong, those 15 children might have done just as well by themselves for the ideographic reasons about which you have speculated. Then one is doing

them a disservice. It is not necessarily a bad thing to identify weaknesses in programs, if the logic is to increase the caliber, relevance, and match of the program to these heterogeneous groups of children. However, it should not stop there. The only way we will attain legitimacy is the same way it is achieved in alcohol treatment studies: by conducting these kinds of matching studies. Similar research is now being conducted in welfare reform and in alcohol and drug abuse. It is time to move to that level of analysis.

Comment: Valerie Lee's opening remarks about a disciplinary difference in the way in which this problem is thought about might be helpful here. Those of us trained in political science, for example, understand that everyone is interested in the action in which they are participating. Thus, random assignment will not control for the problem of how biased participation leads to biased outcome. Economists understand that everybody is interested in the economic behavior of their sample, so they do not try random assignment either. Anthropologists, from their perspective, are interested in the complexities or nuances of participation in life circumstances, so the problem is not one of making random assignment. It is the psychologist and the sociologist who are in the middle of this. Some take a more experimental random assignment view, but tend to feel that one also needs to study the population of these groups. These other disciplines move toward management statistics and population statistics rather than small group studies in order to get a handle on what causal forces are at play.

Lee: I have not seen too many randomized studies in sociology. Sociologists are extremely interested in the group to which the results will be generalized. Thus, sociologists pay a lot of attention, much more so than psychologists, to selecting a sample from some group to which the results will be generalized.

Comment: I would like to make sure that the issue Jack Shonkoff addressed yesterday about the policy component is discussed. Many funding decisions and some major policy-making decisions shape what money is available, how programs are designed, and which programs are continued. Without considering the role policy making plays in our field and how our field influences policy, there is a gap. Policy makers rely on experts, and as long as the field continues to rely on this mixed message about a gold standard of random assignment versus other approaches, they will continue to call on the one or two people who advocate for randomized trials. That is still the definitive approach. Until we get past that, we will not be able to influence policy-making activities or questions that determine how we conduct research.

Comment: The approach of your mission will depend on the question. I hear a lot of top-down thinking about the same questions. The place where randomized research is the gold standard is probably medical research and broad research where there are a series of questions. Their first question is, "Will it work?" Then they come to a second question, "Will it work in the real world?" This is an entirely different question that has to do with self-selection and other issues. There is even a third level, which is, "Does it work with real people in a particular historical or political moment?" There is another approach that helps bring a convergence: finding things that already work in the political circumstances and working backwards.

Lee: We might understand the same question slightly differently. You stated that the first question was, "Does it work?" and then, "Does it work with real people in the real world?" I think the real issue is what is "it?"

Sherrod: Our last question is about dissemination. Someone did an analysis of programs funded by a major foundation and found that there was no correlation at all between the "success of the evaluation" (that is, how much the program worked) and the sustainability of

that program. Other issues, such as political issues, time, and so forth, determined which programs lasted and which did not. The question becomes how do you translate research results into policy?

Cordray: The question was not so much about dissemination as it was how to generate the knowledge to be disseminated.

Comment: There is a group of researchers that continues to advocate that the only gold standard is random assignment. We forget why we do random assignment. We use random assignment to achieve the real gold standard, equivalent groups. Random assignment alone does not ensure equivalent groups. The small sample size selected often will not give you equivalent groups. Even if a researcher achieves a wonderful design that produces random assignment, suddenly a few weeks later, the groups are no longer equivalent. To think that our methods consist only of working as hard as we can to simply achieve random assignment and then walk away and let everything else take care of itself is looking at the wrong gold standard. The real question is how to develop new methods that help us understand all the different ways that equivalence can be achieved and to convince policy makers that the issue is equivalence, not whether random assignment was used or not.

Cordray: I agree the gold standard is not randomization. The gold standard is valid inference about a causal process, which may take more than one study and more than one method.

Hagen: Last year at the SRCD meeting, Mark Appelbaum, a distinguished methodologist and statistician, gave an invited talk about advances made in terms of basic statistical design and methodology in research. He said we have made far more progress in our design and sophistication in what we can do than we have in our instrumentation. Most studies still use instruments that are 20 to 40 years old. We operationalize children's depression with the Beck Depression Scale, how children view themselves with the Harter scales, and so forth. This is the biggest weakness in much of our current research. We ought to be spending more time on designing better and more meaningful measures for the dependent variables that we examine. When one reviews the published studies, one finds the same instruments that are accepted as valid being used again and again. In some of my own work where we used both the tried and true quantitative measures for children at risk and the qualitative measures, we obtained totally different results. What do you believe then? You are back to square one.

Second, I think we are too often willing to assume that researchers in other fields can do it better than we can. Much of the biomedical research is not necessarily that much better, nor is there a true understanding of the mechanisms underlying treatment. At a National Institute of Mental Health (NIMH) conference just 2 or 3 weeks ago, scientists working on schizophrenia presented their findings. We have made tremendous strides in understanding and treating schizophrenia in the last 30 years. I was taught that there were schizophrenagenic mothers, and that the cause was not genetic but produced by the way mothers treated their children. Today, most people accept that there is an important biochemical aspect. However, one presenter pointed out that there are 10 to 12 different medications used to treat schizophrenia and that it is fairly random as to which one works, how much is required and in what combinations. Most people eventually find a combination that works quite well. However, they still do not understand the underlying mechanisms.

Greenfield: The issue of equivalency is right on target. We want to be able to convince policy makers that there is not necessarily a gold standard in random assignment but that equivalent groups are still essential. One way of helping ensure equivalence is by working closely with the Head Start community. If one is a Head Start researcher beginning to develop meaningful

partnerships that involve Head Start staff in making decisions and understanding research, including the factors that may lead to nonequivalence, the chances of producing groups that are equivalent will be increased. You will also have a constituency that can help you support that, indeed, this has been an effective intervention with equivalent groups.

We have a major problem in dealing in the political arena about the notion of the need for random assignment and the need for measures that have been used before, even though they may not have been used with a Head Start population. We often are forced into corners where we have to use instrumentation that we know is not appropriate for Head Start. These measures will not give us the answers we are looking for. Many politicians only want to see changes in IQ or achievement. Unless one uses those measures, which we know in many cases are not going to show the impact of our interventions, one does not satisfy the policy maker's information needs.

Slowly, people are beginning to develop new and valid measures. A number of the poster sessions and presentations at this conference include researchers who are developing measures for use on Head Start populations. They have compared them to measures not used on Head Start populations and shown that their measures are more valid and represent the constructs that they are trying to understand. If we can continue to spread this information among the community and get more people to use these measures, we will be making progress. However, it is an uphill battle.

Lee: Some of the responsibility that we as researchers have for influencing policy falls only on our shoulders. We have to make our writing conform to the standards of journals where we publish, but we also must write for a broader audience. It is hard to meet both standards. One may have to present one's research with graphs instead of only words. We have to push ourselves in order make our work appeal to more than just the academic audience. On the other hand, because I do a lot of policy research, it is my responsibility to talk to reporters and try to help them understand our research.

Comment: I would like to address the issue of partnership and the implications that it has for equivalent groups. Achieving equivalent groups is not just a problem at the beginning of the study. Attrition is also a major problem. One of the things about working with a partner like Head Start in the schools is keeping track of the families in the control group to make sure that they remain in study. The down side of a partnership, though, is when your partner calls 3 years into the study and explains that they received the funds to implement the treatment in the comparison schools.

Sherrod: One issue that always comes up in any review or evaluation study is the number of sites and site variability, because you want more than one site in order to address generalizability. On the other hand, with more sites you increase program variability, which can wipe out any significance you might find.

Cordray: Having a variation in effects is helpful rather than hurtful, if you can tag them to something programmatic.

Question/Comment: One aspect of evaluation that has not been addressed is ethics. Often school entities and families resist scientific research. Furthermore, researchers seem to believe that scientific discourse is the true way to verify policy decisions. At a conference like this, people are aware that it is a two-way conversation. How can we incorporate the knowledge that people have about how programs work? How do we incorporate the contributions of our participants and our partners? There still seems to be an effort to use these models to help sell the program. Generally, evaluators attend these conferences, not school district representatives. The idea of there being a Head Start research conference does not resonate downtown.

Greenfield: To some extent you can try to get your partners to help you tell the story. When you first start working in a community, you are going to run into resistance. There is no question about that. People will question the researcher's motives. As researchers, some of our motives have nothing to do with helping children, families, or programs. However, if helping is one of our motives, and we translate this so that the programs, families, and children we are working with understand this, then they also can become partners. It requires a lot of listening. We need to understand their interests and their language and help them understand ours. Researchers have to be able to explain to practitioners why research can be meaningful to them, why they should want to participate in research, and why they should want to help in deciding how it is done.

If practitioners can see that the research is useful to them and that the results potentially have implications for program improvement, then they become invested in the study and the research is partially theirs. Program directors and staff may not come to this particular conference to tell their story, but they may go somewhere else and talk to local officials or people at the state or federal level. The more people telling the same story, the better chance we have for that story to continue.

Lopez: The economist's contribution has to do with understanding that the selection mechanism is key and that we need data on it. Program participation is tied to motivating people. They enroll and unenroll and participate in program elements if not in rational ways then, at least, in deliberative ways. For example, we cannot expect a program to work the same for all people. There are differential effects. We find that the program works differently for some people than for others. Unless we understand the selection mechanism, we have no way of knowing whether the people who were selected into the program were just different or whether the program actually worked differently. One example is the fadeout effect in certain minority groups. We do not know if that is a function of better outreach in certain communities where we draw individuals who have more problems and are therefore less responsive to treatment or if it is truly fadeout.

People always note that Head Start does not enroll all eligible children. Yet we have very little sense of who enrolls in Head Start. Data from the ACYF FACES study will help. If I were to evaluate local Head Start programs to know which children were enrolling, I might try something as simple as taking census data and examining all 4-year-olds in certain tracks in the catchment area, comparing Head Start children to children who did not enroll in Head Start. I also might look at who applied versus who enrolled in Head Start. But first, short of adopting econometric methods, I would try to learn as much as possible from data on other people who were not in my program.

In addition, I would focus on the demographic measures that psychologists use with people who are very poor. There is often only a single dimension of socioeconomic status. Therefore, our data show that the groups are comparable, when in essence they are not. Most of the questions that you raised could be examined within a single study, if the sample had enough people of different categories. A lot of small studies do not always add up to one bigger one.

Cordray: Any research design has tradeoffs. If there is not a large treatment difference, you need a big sample. However, if there is a big difference between the two groups with regard to the intervention, you do not need a very large sample size.

Greenfield: We underestimate how difficult it is to measure anything carefully and will spend years trying to solve that problem. We tend to be narrow minded in our own field. As psychologists, there are some things that we measure better than any other field, but there are other things that we measure much more poorly than other fields. Unfortunately, there is a tendency not to read other literature.

The extent to which we can utilize how other fields measure constructs that we need to understand better, and then help these measures gain acceptance in our field, will enable us to have more valid research. There is now a movement to analyze these issues by looking at other kinds of large data sets to make inferences. We are doing that in Florida. However, it has been fairly difficult in terms of issues of confidentiality. Historically, incompatible computer systems were a problem, but the computer field is advancing rapidly. Over a number of years, the relationships we have made with the State Department of Education convinced them to give us access to all the educational data in the state. We are in the process of getting information on criminal records. We have a fair amount of Head Start data as well as birth records for everyone in the state. It is taking a long time because we have to insure confidentiality. New York and Philadelphia are beginning to implement similar studies. Over the next few years there is going to be data demonstrating these relationships, and then we will be able to use large census data to provide a backdrop for more focused studies.

This points to the importance of multiple methods and examining questions in multiple ways. Large data sets are nice for certain analyses and answering certain questions, but they have their limitations. You have no control over the quality of the data or the nature of the information. That kind of information, in conjunction with more focused studies, will in the long run help us understand the important questions in our field.

Question: If a program is found to have failed, how does research determine if it was the theory behind the program, the implementation of the program, or the evaluation method that did not work?

Lee: This is an interesting question, but the dilemma is that it is very hard to get funding to examine why a program did not work. You have to show some success. Generally, the engine that keeps research going is being able to obtain external funding to conduct it.

Comment: I would like to return to the comment that multiple small studies do not add up to a big one. We can look across numerous studies with different components to find consistent findings. That is much stronger than one small component.

Lee: The experience of the Consortium for Longitudinal Studies, a 10-year collaborative national research study which has not been replicated, is a question of bringing numerous small studies together and getting something big out of them. The issue was to get enough studies together to somehow have the power to demonstrate an effort.

Cordray: Today, federal agencies seem to be very interested in more large-scale studies. We are seeing more funding previously allotted to individual research grants directed to multisite studies. The National Day Care Study is a prime example, funded by the National Institute of Child Health and Human Development (NICHD) for $30 to $40 million. The decision was just made to conduct a follow-up to that study.

I have heard at various conferences over the last year or so arguments for both large and smaller multisite evaluation projects. Societies like the SRCD and the American Psychological Association (APA) are hoping that primarily individual grants will be funded, but that is not the direction things are going. I am on many panels of multisite evaluations. One thing that worries me is that people try to aggregate the data as if it were one study. That is probably a mistake. The other alternative is to look at issues at an individual-site level and then aggregate it with the power of meta-analysis to explore the variation in the effects rather than bury them in an overall analysis.

Comment/Question: I am interested in the relationship between design and analytic strategies. There has been discussion about the limitation of experimental design, but I wonder if that is because of an inherent design limitation or whether it is about needing more creativity in analytic strategies. For example, if you have good comprehensive baseline data, then perhaps you could do some analyses that help explain differential attrition between groups. Is that possible?

Cordray: The first part of the discussion that you missed basically asked over what sources of variation do we not have any control. The statistical model that one uses ought to reflect one's thinking about the sources of variation that one needs to be able to account for in that model. Therefore, it is very important to examine sources of variation, especially if one suspects that there will be attrition or people who self-select out. It is also important to examine the intervention itself and how strong it is relative to the control condition, which is something we have not talked about. Are there mediating mechanisms that are proposed as part of the model? In other words, one needs to think more about the intervention conceptually and operationally, and then measure the necessary components so that one can appropriately use econometric-type models. One does not have to rely as much on the simplistic, input/output randomized process, if one can think better about the model operationally and conceptually.

Comment: One thing I have found in studying Chapter One funding for schools is that many people here have said that they would be interested in comparing program participants to a control group because many eligible children are not served. However, in Chapter One funding, which provides funding for schools across the nation, we had a large longitudinal sample. I found that the students who had Chapter One funding for the most years had the worst outcomes. The ones who had only 2 out of 3 years did a little better. Students who had Chapter One funding only 1 out of 3 years did a little better. Students who never received the funding had the best outcomes. That finding does not mean that Chapter One funding is bad. It means that the students who received Chapter One funding were the ones who needed it the most.

Researchers have to be careful in establishing equivalence with control groups. Perhaps the children and families who stay in the services are the people who need Head Start the most. Conversely, perhaps the people who stay in the services are the ones who are the best off.

Cordray: That should trigger a concern about the personal factors that lead to differential use of service and the program factors that lead to differential use. This is the broader thinking about the model that needs to be done because we also can create models of this type.

Language and Communication

CHAIR: Aquiles Iglesias
DISCUSSANT: Elizabeth Sulzby
PRESENTERS: John Baugh, Elizabeth Pena, Carol Westby

Aquiles Iglesias: To begin, I should mention that when we were trying to come up with a title for this presentation, we had all kinds of very interesting ideas. One of the titles that I wanted that I felt might get the attention of many of the participants of this conference was, "Not the Peabody, Stupid," meaning not to use the Peabody Picture Vocabulary Test as a measure of language since using it tends to perpetuate the idea that it is measuring language ability. We decided that Language and Communication was a more appropriate title.

John Baugh: First, I would like to formally congratulate Aquiles Iglesias on his recent award of a major NIH grant to develop new language diagnostics for Latino students. It is long overdue.

I gave some thought to why anyone at a Head Start conference would be interested in language issues. Often, as a linguist, I go to conferences and feel like the Rodney Dangerfield of social science. What can we do to get respect? Everybody is very familiar with language. You have all learned how to speak and did so before you developed long-term memory, so linguistic behavior is something that is often taken for granted.

However, many of the children that you care about will become students in programs where they will be tested, and frankly those tests tend to be biased, often in ways that are detrimental to those students. So the paradox that we face is one where decentralized education in the United States does require nationally norm-referenced tests, but children from culturally and linguistically diverse backgrounds are often inadequately represented by those instruments.

How did this happen? One of the reasons is that there are a lot of misperceptions and misunderstandings about linguistic diversity in the United States that permeate society in very broad ways. I am going to try to frame these issues in linguistic terms. I will touch on the issue in schools and standardized tests and how this is relevant to the larger society and, in particular, to the populations that are served by Head Start.

One of the reasons that there is a misperception about language has to do with the social stratification of linguistic diversity. When people conceive of a language they may think about the dialects, but they often do not think about the linguistic variability that takes place across class lines and within the different dialects. This model of language has upper-class to lower-class dialects, but what is important in this model is that there is a formal manner of speaking for a person who speaks a particular dialect, and the informal manner of speaking. Therefore, no matter who you are, you have a range of formal to informal speech. That also ties in to your linguistic competence. If for any reason the Queen of England walked in right now to see this presentation, I have the linguistic competence to say, "Hi, Liz." However, I also have the social competence to know that that is not how you address the Queen of England.

We have empirical evidence from linguistics that shows that the further down the socioeconomic scale that one moves, the range of linguistic variation between the formal to informal styles widens. The low-income and minority students who are often served by Head Start grow up in communities where there is this wide range of linguistic variation that has consequences for their prospects in school.

In some previous research, I found that from the standpoint of communication, if one looks at a bilingual situation with standard Spanish on the one hand and standard English on the other, there is very little linguistic overlap. It was different with African American street language in contrast to standard English. By that we mean that if one is a monolingual speaker of either language, essentially one will need a translator to communicate. However, in a bidialectal situation there is so much linguistic overlap that even though communication might break

down, and there might be some misunderstanding, the likelihood of needing a translator for that purpose is not as high.

Some people often assume that with radio and television we would all just go through this linguistic homogenization process and these dialect differences would collapse. Why have they not? It corresponds to the social milieu. From a social perspective, one could use standard Spanish or standard English for many of the same institutionally sanctioned purposes, so if I want to study physics at the University of Mexico in Mexico City, I can do that in standard Spanish. However, if I want to study physics using the African American vernacular, there is no place I can go, even historically Black colleges. So the number of social domains where the street dialect and the standard dialect are acceptable are actually quite small. It is that isolation in social domains that maintains much of the linguistic distinctions among other factors, including attitudes.

Early on, in regard to the African American situation, many people have become confused over the assumption that terms such as African American English, Black English, or the controversial term, Ebonics, somehow apply to the entire racial group. Many of the children who are in Head Start programs do come from backgrounds where standard English is not native.

The model that I have looked at is one where the child's interactional domain is very important. Children whose parents have very limited contact outside of the community in their domestic, occupational, and recreational situation, for the most part, are at the nonstandard end of the continuum. However, one will find African Americans and other minorities who have very limited contact with people of their same racial background. I was born in inner-city Philadelphia. Then my family and I moved to California. My father worked in the aerospace industry and we moved into a predominantly white neighborhood. I eventually went back to Temple University where I was an undergraduate in Professor Iglesias' department, and I have lived in North Philadelphia. Now that I am at Stanford University, unless I go to a minority community, I am just like Bryant Gumbel.

In order to look at this, I am going to present a model that is inadequate but contrasts sharply with what we are looking at in the Latino situation. Many years ago when I was at the University of Texas, I was asked to contemplate how the African American situation corresponded to that of bilinguals. When I was looking at Chicano English on the one hand and nonstandard Spanish on the other, I realized that bilinguals are actually juxtaposing two linguistic continuums between the standard norms in both languages, colloquial varieties of English and perhaps colloquial varieties of Spanish. The variety of the second language that one learns depends, however, largely on the nature of the interaction that one has.

So in New York City, if a person from a Puerto Rican background actually speaks a lower variety of nonstandard Spanish, with what variety of English will they be interacting? What we are trying to look at, and what I look at as a linguist, is the social stratification of this linguistic diversity, which for many people is very deceptive. One of the reasons for that deception has to do with misunderstandings about the nature of linguistic diversity in society.

For most of the work that I do, I am interested in dividing us not in racial terms, but in linguistic terms. I have used the concept of the dialect of wider communication because I think it carries less baggage for people than does the term standard or nonstandard. I am not trying to imply that standard is somehow superior. The dialect of wider communication essentially corresponds to that.

The reason that these divisions have been so critical in my work in education is that teachers and those of you working in Head Start are faced with different linguistic configurations of people that are served. In upper middle-class neighborhoods, teachers often find themselves in situations where most of their students are middle-class or upper middle-class and there is very little linguistic diversity. However, for those of us working in Head Start and linguistically diverse communities, we are in situations where there are primarily students whose backgrounds are either nonstandard or where English is not their native language. What we find is that native standard English speakers are really the minority in those situations.

Now, when I speak about linguistic variation it is important to recognize that some of these issues are far more complicated than meets the eye. If one takes negation, for example, and takes the standard sentence, "He does not have any," one might write that, but one is unlikely to say that. In standard English, one would contract to "doesn't" and would produce the spoken form. So typically the native standard English speaker writes, "does not" and says, "doesn't".

Everyone in this room, though, has the confidence to produce nonstandard sentences. In Chomsky's terms, all of these sentences would have the same deep structure. I do not want you to get too far ahead of me, but if "doesn't" is changed slightly to "You don't have any," then "any" can be changed to "none." "Have" can be changed to "got" and "don't" can be changed to "ain't." "He ain't got any" and "he ain't got none." So what teachers face, and what many of you I hope will appreciate through this presentation, is that when children come from diverse linguistic backgrounds they will often carry additional linguistic baggage that is potentially harmful to them in an educational or a testing situation.

Many people who learn standard English natively say that it is not that big of a deal to simply just substitute one form for the other. That is not the case, however. One of my favorite examples comes from the movie, "Hollywood Shuffle" where the sentence "I ain't be got no weapon" is used at the very outset of the movie. In trying to translate that to standard English, one can eventually get to, "I do not possess a weapon." In my own field work in California, I identified a sentence that clearly shows the complexity of these two forms. Two young women who were rivals for the same young man were in an argument, and one of the women was about to go on a date with this guy to an amusement park wearing platform shoes. The sentence reads: "There ain't no way no girl cannot wear no platform shoes to no amusement park." If literally translated into standard English, the sentence has exactly the opposite meaning of what is intended. So when people simply tell a child who speaks nonstandard English to simply substitute one form for the other, it is not as simple as that.

Let me give you a very brief insight into this linguistically. For example, when you have "no girl" versus "any girl," from a semantic point of view, no girl excludes all girls. Any girl includes all girls. It is kind of like a mirror image. It conveys the same impression in terms of the sentence, but trying to tell a student that you can just substitute any for no does not really take that subtle semantic difference into account.

I was on the Gordon Elliot Show after the Ebonics controversy, and one of the speakers who was African American said there is no difference in standard and nonstandard English, and that White people use nonstandard English, White people say "ain't." In one sentence one of my subjects, who is African American said, "I ain't run the stop sign." Now, the use for "ain't" for "didn't" typically occurs with African American nonstandard English, but one very seldom finds White people who use ain't for didn't. Even if one wanted to substitute ain't for contracted forms in standard English, one cannot simply say, "Ain't be a litterbug," instead of "Don't be a litterbug."

The substitution issue gets far more complicated than people realize. Yet these students are expected to perform well when they are given tests. However, what we see is that in their adult lives, they make linguistic accommodations that are intended to gain respect from the people from whom they seek respect.

An example is the linguistic styles of four African American, teenage males. Coco and Juan are brothers. They do not have the same father. Their mother is drug-dependent, alcohol-dependent, and has had a great deal of difficulty in her life. As teenagers, when these brothers used a sentence where there was a negative form, they used a nonstandard form. As adults they made substantial accommodations. Coco eventually went into the army, worked his way up through the ranks, and became a sergeant. Russell and Leon are also brothers, but their parents are middle-class African American. Their mother is an elementary school teacher and their father is an attorney. However, when they were hanging out as teenagers they used a nonstandard vernacular because they wanted to identify very strongly with their group. Another factor that is operating here is that at least for many of the non-White minorities in these circumstances, their

linguistic identity is tied very closely to the colloquial vernacular.

As an adult, Juan committed a murder during a gas station robbery and he is doing a life sentence in prison. Thanks to a grant from the National Science Foundation, I was able to interview all of the men over a 10-year period. When I interviewed Juan in prison, one of my routine questions was, "Well, what is the value of standard English in your life?" After he stopped laughing, essentially in his vernacular, he said that anyone in prison who embraces standard English too enthusiastically is likely to be sexually victimized. He did not say it in those words, but he conveyed it effectively.

Russell owns a hardware store in the African American community and he is very adept at style shifting. His brother Leon eventually went to work for IBM. What my data showed me as a linguist over time is that African Americans, from various backgrounds, as teenagers may do one thing, but they make accommodations in their lives, depending on their life circumstances. These young men are no different from the rest of us with respect to shifting our speech. When we need to, we become mature and are aware of our linguistic presentation of self, and we try to speak in a manner that is designed to gain respect from the people from whom we seek respect.

The last linguistic piece of data that I want to present is one that looks at the amount of absence of suffix S forms. Whether or not a person uses suffix S shows up frequently in diagnostics that are used. From a functional point of view, we can begin to see why these different suffix forms do not occur with the same regularity in the African American dialect. Plural S is likely to appear. Possessive S is often deleted and third-person singular S, such as in "He likes cars," is almost never there. One of the reasons for that is that there is a linguistic justification. Often the plurality is conveyed exclusively through that S, so if that S is not there, the sentence is ambiguous. However, in the case of probability or in third-person singular S, it is almost never ambiguous if the S form is not there. In a sense, the nonstandard dialects have done what we have seen classically throughout linguistic history. They have done some linguistic pruning of information that is nonessential. In terms of testing diagnostics, when we look at standard English in society, what has been very efficient through the linguistic evolution of African Americans and other disenfranchised groups turns out to be problematic in a testing context. What do we do about that?

We certainly do not want to cut the bilingual education programs like Governor Wilson has done in California, because essentially that will remove a great number of the resources that many students need. In terms of speech or in terms of using language effectively in school, the native standard English speaker develops at a normal rate within a single monolingual language context. However, it essentially takes 2 years for someone who does not have native English proficiency to catch up so that they can interact in an oral mode. It takes 5 to 7 years essentially to close the gap so that they can effectively produce academic discourse. If we simply put students in a program of one size fits all for 1 year (which has done in California and is supported by the very people who are otherwise in favor of school choice), a mistake will occur that is going to have consequences that are quite severe and quite negative for those students.

What are some of the productive strategies that we can do based on linguistic information and insights? First, we need to inform test developers and policy makers about this linguistic diversity. It is not simply the fact that people who do not speak standard English are willfully and randomly misusing the language. Resolving the testing paradox has inherent political considerations because testing and fairness issues tie into the current debate on affirmative action; and for that matter, many people consider Head Start to be an affirmative action program. Many are under the impression that if modifications are made, that somehow gives advantages and yet many of you in this room recognize you are overcoming disadvantages from the past. As we overcome disadvantages from the past, we want to provide fair diagnostics that do not provide misleading evidence.

At the present time, many norm-referenced tests imply that everyone comes to that testing situation from a similar background and that is simply not the case. We want to reduce misdiag-

noses of students for whom standard English is not native. This includes most of the children who are served by Head Start. This needs to be done in a systematic and coordinated way so that we can enhance prospects for success in a variety of venues, including education policies and their implementation.

In summary, the short-term solution—and we can have a short-term solution—is first, to describe some of the limitations in the existing tests. I was fortunate enough to have dinner with the trustees of the Educational Testing Service a few weeks ago and I pointed out the paradox that if students from different linguistic backgrounds are taking their test, they are not getting accurate representations of their intelligence. I felt that ETS has a responsibility to inform the public of some of the limitations of their tests. They are reluctant to do so for obvious reasons.

Second, if you do not want to disclose the limitations of the test, you could provide more detailed information about the test takers. In places such as the University of California at Berkeley and the University of Texas where they have had legislators coming in and saying that they do not want to use affirmative action anymore, you can help by providing additional information about the background of the test taker. In that way, admissions officers or others can have additional criteria to consider for admission decisions or the distribution of other resources.

We could also describe the professional qualifications of individuals who are best suited to deliver the test. Right now, in many situations, there is an assumption that a test needs to be written in such a way that any professional should be able to administer the test. What we often see, however, is that someone with additional insight into the culture or background of a particular group may be better suited to give that particular test.

We should always strive for fairness. I think being politically aware of the fact that some individuals perceive these adaptations as somehow providing disadvantages for some groups at the expense of others is inappropriate. We need to be aware of the fact that we are operating within a political context.

Carol Westby: I am going to continue discussing the issues around language and language testing. For many years, I have been in New Mexico working with Hispanic and Native American populations. I have also been in Wichita, Kansas. Interestingly, that city has a Head Start program specifically serving Asian children. I agree with John on the need to be aware of linguistic diversity.

I do a lot with ducks and birds. I have had a pet duck for many years and I must be sensitive to the fact it would not be an articulation problem for a duck whether he is saying quack or crack, since it could be a dialect difference. I am not going to consider this an error. However, in thinking about language, we need to go beyond just the linguistic structure and the phonological system to realize that an even larger aspect of language has to do with the communication rules. Those have not been recognized.

In a cartoon, a man is attempting to speak to a duck. He tries several languages. Sprechen sie Deutsche? Habla Español? Parlez-vous Francais? Finally, he tried quack, and they carried on a conversation.

I knew that when my duck would go "quack quack quack," it meant he had just seen one of the big black New Mexican cockroaches, the chocolate chips of the duck world. I knew that if the quacking sounded slightly different, it meant that we had left him outside and everyone else was inside. So I spoke quack. The following year, my duck began following me around, nipping at my ankles, and biting me. I looked at this behavior and I thought that perhaps something was wrong. I took the duck to the veterinarian. I found out that this duck was now sexually mature. The duck was a drake and he was propositioning me to be his mate.

There was obviously serious miscommunication, even though I thought I spoke the language. Sometimes some of the students that are the least well-served by our course are students who we think speak the same language that we speak. We try to push children through inappropriate

kinds of testing, such as the PPVT or preschool language assessment scales. Does this make sense for the children with whom we are working? We are working with children who come from a range of environments that diverge from their experiences. We have to think about what children are socialized to and what the expectations are.

I am interested in trying to provide assessments for students and identify those students who are at risk for language learning. One of my interests in living in New Mexico is that we have an extremely high rate of students who have difficulty with literacy. In fact, much of our state data show that the longer the children are in school, the worse they get. In the native population with whom I work, children start out at the 25th percentile when they come in around first grade. By the time they are in sixth grade, they are at the 15th percentile in reading. What is going on?

I want to be able to identify students who are specifically at risk for language learning problems. I know there are differences. I do not want to say all these children are disabled language learners. What I do want to do, however, is find out which ones are particularly at risk for learning language well. That is what we want from a test.

I am going to share some things about cultural variability and socialization, but I want us to be careful and not jump and say that is what everyone from that particular culture would do. My pet parrot is a New Mexican parrot and he loves chili peppers. So every day he gets a chili pepper. When we think about culture and some of the things I am going to be sharing with you, realize that all of us are a blend of cultures. Part of our culture can be our background, our birth history, particularly if you were raised in the culture of your birth history. That is part of who you are. Part of who you are is also your unique experiences. Even if you have a twin brother or sister, you have experiences that that individual has not had.

Then there is a part where all of us share pieces of culture. That is why I say all of us are multicultural. This includes the region of the country in which one lives or whether one is from an urban or rural area. Living in Washington, DC, is not like living in Albuquerque, New Mexico, which is not like living in Wichita, Kansas. In moving to New Mexico, we experienced real culture shock. There also is the educational background one has. All of those pieces become part of your culture.

Now, let us look at some of the differences in socialization. Many of our studies have looked at mother/child issues and how much talking goes on. Some of the literature during the 1960s suggested that low-income families tended to talk less. Field and Widmayer were rather interested in that and they thought it was not only associated with income levels, but was probably also related to some other cultural expectations and the valuing of verbalization. They looked at mothers in Miami that were from Puerto Rican, Cuban, South American, and African American families, and looked at the amount of talking that went on with their infants. There was quite a bit of variation, with the Cuban parents talking 82% of the time.

Aquiles Iglesias had mentioned at one point that he thought part of that might have been emphasized because the initial families that came from Cuba were educated and used to being very successful. Miami quickly implemented bilingual classes, but the children perhaps initially were not as successful as the families expected. The families checked around and realized that in mainstream classes in the United States being verbal is valued so the families really began talking more. The Puerto Rican families talked about half the time during the taping and the African American mothers talked about 15% of the time.

Instead of just assuming the African American mothers were not interested in talking and did not know how to talk to their children, fortunately Field and Widmayer interviewed them. The mothers said that they had noticed that a good mother should not have to talk all the time. Instead of asking if their child is hungry now or if their child wants mommy to feed him or her, they should be able to read the infant's cues. They felt that a mother should be sensitive to their infant's needs and be able to meet those needs. A good mother does not need to get that

through questioning. Another fact was that they wanted their infants to eventually become more independent. They saw all of this talking as not contributing to that end. Therefore, there was a value difference put on the talking.

There also were differences in the kinds of games that were played. Some were instructional or comical games and others involved labeling things. In any culture, reading is typically considered a good activity. Someone brings out a book, and he or she labels the piggy, the doggie, and the horsey. Not all the groups were so much into labeling. Some of them were more concerned with social interaction games such as patty-cake and peek-a-boo.

What happens in our testing is that we do not test social skills unless one is really bad at them. We do not look at the children who have really good social skills and know how to negotiate with one another. One study showed differences in rhythmicity in the interaction. We talk about communication often being a dance. How does that rhythmicity develop? We studied African American, Navaho, and Anglo families and mothers, looking at how they negotiated this dance. The Anglo mothers would verbalize with the infant, the infant would turn away, the mother would verbalize again, and the infant would come back and the dance would repeat itself. The African American mothers would verbalize, the infants would turn away, the mothers would keep verbalizing, and the infants would turn back, so there was ongoing verbalization. The Anglo mothers tended to do what seemed to be disruptive to the infants. Neither of those results was particularly unanticipated because we have previously looked at how mothers engage their infants. The assumption was that mothers who had more rhythmicity in their language would engage the infants better. Indeed, that was true for the African American and Anglo mothers.

For the Navaho mothers, the more rhythmical they were in their communications, the less the infants attended. Many of our infant programs get parents engaged in this interactive rhythmical language and think this is really going to be good. What is going on with this other population? All of the mothers were equally successful in getting their infants' interest and attention. They all had a system in place. We do not know how the Navaho mothers were doing this because the assumption of the researchers was that it is verbalization that enables you to make this link.

There are differences in the amount of time that children have with mothers, and I am going to look at how that then might impact on communication. Are we addressing the issues of nuclear or extended families, and what are the roles of the siblings?

I know that in other presentations you have already heard information about the work of Hart and Risley. They followed a number of families at different income levels, looking at just the number of words that children heard addressed to them. Professional families' children heard 40 million words by the time they were age 4, compared to welfare families' children who heard 10 million words. There were marked differences in what the children were hearing and vocabulary differences by 36 months.

Therefore, we know that a number of the children we see have not had as much exposure to language. That still does not tell us whether or not they are good language learners. On a test, it shows that they do not have as many vocabulary words, but that does not tell us whether or not they have as much ease at learning languages as another child.

There also is variation in socialization practices. We can look across cultures and think about the degree to which children are socialized to be interdependent or independent. All cultures socialize to both but to varying degrees. Mainstream North American cultures tended to place more emphasis on independence and as part of that, children are encouraged early to be assertive and have self-direction.

Some cultures focus more on interdependence, such as responsibility and the sensitive reading of cues of others. A number of the Asian cultures have focused more on this interdependence. Again, realize all cultures are socializing to both. Some of both are needed. However, one culture might be focusing a little more in one direction than the other. Heath talked about how African American families are doing both. They want the children to develop independence, and

those youngsters are encouraged early to stand up for their rights, to hold their own. At the same time, they are encouraged to be interdependent. They are involved in childrearing and are responsible for siblings.

Within many of the Southwest native cultures, silence is highly valued. One should watch and listen until one knows what the situation is. Martha Crago talks about that with the Inuit population. She was trying in the preschool years to obtain some good language samples from these children. She thought snack time would be a very good time to get it. Children ate in silence; they did not say a word. She said to the native teacher that she was trying to get language samples and thought snack time would be a good time; but the children did not say anything. The native teacher said, "We have noticed that when White people eat, they talk a lot. We have decided the food must taste so bad that they talk so they do not think about how bad the food tastes." That is a difference in socialization.

If you have not seen the videotape, "Preschool and Three Cultures," I would recommend it. In that videotape, a preschool in China is shown, and as the teacher passes out the luncheon meal, she says, "Concentrate on your eating just like you do your studying." The meal was eaten in silence.

What is the difference in verbalization? What happens when we come in as a tester and start off talking and really do not spend any time sitting, watching, and listening? We come in and we start bombarding them with questions.

There are additional differences in cultures. At what point do they believe the child is intentional and responsible? Mainstream culture treats an infant as a social partner from the beginning. Many other cultures vary as to what stage they believe that the child becomes a social partner. If one is not viewed as a social partner, think about how that might contribute to some of the early language development. In cultures where the child is a social partner, the infant looks at things and the mother starts labeling. If one is not viewed as a social partner, what kind of engagement is going to happen? What kinds of words and things will the infant pick up on? He or she will pick up on the words that are said with intensity, the words where something exciting happens. Therefore, some of their early words end up being action words. Sometimes they end up being words we really do not want children saying. For example, one trips over the dog and spills spaghetti, and then curses. Sometimes a curse word can be an early word because of the excitement that happens around it. In these cultures, early words are likely to be those that are attached to something happening. They are going to be more action words and it is difficult to put action words on a Peabody.

I know a Native American woman who finished her degree at Stanford last year in a native studies program. She is now working on a master's degree in bilingual and special education. She is doing outreach work and she said to me, "I am really trying to figure out how to look at some of this stuff. Our language is a verb-based language. All of the early words are verbs. I cannot even think of what would be noun words. Our language is based on a verb structure system and morphemes are added to the verbs that describe action with the verbs, as opposed to being a noun-based and adjective system."

It is important for the tester to know if the infant or toddler or young child is expected to be an information receiver or an information giver. If a child is from an environment where he or she is a receiver, his or her receptive language may develop well. However, if the tester comes in and now wants the child to talk, this is a problem because it has not been his or her role to be an information giver.

Let us add some other things too. What skills are valued? Mainstream culture particularly values verbal skills more than social. If a child comes from an environment where the family socializes him or her very early and expects him or her to know how to be polite, how to sit, and how to listen, it can be done. Even mainstream U.S. culture does not value that early development of emotional maturity and stability. That comes later. I would not expect that in a 3- or 4-year-old.

Let us look at some other aspects that affect testing. In testing, we tend to value time frames. In mainstream culture, there is a real focus on monochronic time. We do this and then we do this and then this. When the child is tested, the child cannot after two questions say that he or she remembers what the answer was to the first question. The tester would say that the question had already been marked wrong and that the child could not go back.

We time infants even on the Bailey. Faster is better. There are many cultures where faster is not better. There is a polychronicity to how things are done. I can do several things at one time. We get children in test situations and tell them to put the pencil down since they are not doing that portion of the test now; right now we are doing this. That is not an experience that the child has been used to, if they come from an environment where the specific time is not that critical.

Test cultures assume one learns by telling and that if one is told, one could do the task right now. For example, I am giving you the instructions for this test. I know you have never seen this before and in fact I do not want you to have ever seen this before. I have told you right now what you are to do. The children just look at me. They are involved in a culture where they were taught to watch and listen. I did not show them how to do the test. I only told them. They sit and wait. Sometimes they try something but most of the time they do not try anything. The native cultures with which I have been working watch and listen so they will know how to do it before they try it. It totally goes against how we do testing. Translating the test is not the issue. It is what the expectations of behaviors are within the test.

Mainstream culture says we value what you can do. Do the best you can. If one is from a very strong collective culture, one does not want to make oneself look different from someone else. One wants to check how somebody else is doing with this. If one is trying to do a group test and one is checking to see what others are doing, we call that cheating. We have heard explanations such as, "Well, I helped her because she was having trouble so I showed her what the answer was." This child was thinking that she was not cheating if she is in a collective culture. She was thinking, "I am not going to make myself stand out. I am going to help everyone in my group do a good job with this." Our culture puts people on a hierarchy that is not comfortable in a collectivist culture.

Test cultures use pseudo questions. If I did not have my watch and I asked what time it was and you told me, it is because I was asking because I needed the information. Test cultures use these pseudo questions where the answer is already known. There are many cultures that do not play this pseudo question game. Heath talks about that. In the African American community she studied, the main time a pseudo question was used was when the child had done something wrong, such as, "Who spilled the milk all over the floor?" The mother knew and the children knew. A psychologist said to me, "I think I now understand what has happened to the number of children I have tested on the WISC-R." There was a question about who discovered America and she said that she had several children say it was not them. They do not know who did it but it was not them. They did not do it!

There are differences in testing than in everyday conversation. In everyday conversation, everyone talks and helps one another. In testing, you have to do it all by yourself. One has to be socialized to that. In a test culture, we want you to make sure you talk about the topic. Did you see the elephant? He is big. He eats a lot. Everything must be very clearly linked. If I am giving the McCarthy and I ask what a coat is, I do not want the child saying, "My brother has one and it is new and mine is dirty." I want the child to stay on the topic.

In many cultures, in social interaction one talks topically. We will talk about the dinosaur, then a child says that he saw an elephant. The elephant was big. One idea leads to another. Many speech pathologists have been trained to see this as a problem: If children do not maintain a topic in the way it is expected, it is a sign of a language disorder. This would be untrue if one has been socialized to making links between ideas.

Where is the meaning? Tests assume that one gets the meaning from the text. All mammals are warm-blooded. Cows are warm-blooded. Is the cow a mammal? The child cannot say, "I've

never seen a cow." One might say, "That does not matter. I gave you the question. Is the cow a mammal? It is warm-blooded." The child might say, "I do not know what a cow—" The child might be interrupted with "It does not matter. Answer the question." This kind of thinking gets very attached to literacy across the world. It is how literacy is used. The more one gets involved with literacy, the more one does this.

In many cultures and in cultures that use primarily oral language, the meaning is in the situation, in the context. An ad for a certain optical medicine came to my home. My husband is a pharmacist. This says nothing to me. Only a member of the pharmacy community can understand it and know that this is an eye medicine and it has only been available from Sweden. That is context communication. It happens sometimes in professional communities, in our families, and in communities. With children who only have had exposure to a particular kind of language, they are not sure what to do when we tell them all mammals are warm-blooded and a cow is warm-blooded, and then ask if is a cow a mammal.

Not only do we need to think about the use of vocabulary and questions, but we also need to realize what happens in broader discourse. Many people think that we should start children storytelling. Who tells the story? At what age are children expected or allowed to tell stories? For example, a native Zuni working with me told me that in her culture, children learned to tell stories publicly until they were adolescents and then only the boys had the right to tell them publicly.

What are the different functions of storytelling? Do you tell imaginative stories? What kinds of stories are told, and in what context? How is one socialized? What is the structure? We talk about stories having beginnings, middles, and ends. That is three parts. Southwest native stories have four parts. They do not have a beginning, middle, and end. There is a beginning and there is something, something, and something that maybe wraps it up, but not in the way we expect. Children are socialized to that very early. We did a series of Three Little Pigs stories from different cultures and asked the children to do their own versions. One of the children wrote, "The first little piggy went north, the second little piggy went east, the third little piggy went south, and the fourth little piggy went west. So even though he heard only three pigs, because of his story, he increased the number of pigs to four.

There was another story of a bird that flew around the world four times. Native and Anglo adults were given native stories and Anglo stories. The native adults tended to add an extra piece in the stories that they heard and the Anglo adults tended to get rid of one of the pieces in the stories. None of them was aware that they had done that. Some might say it was a memory problem or they confused the story but that was not what happened. One is socialized very early to what the expectations of those stories are. The content and theme is going to be different. Perhaps the words are understood, but how will they be interpreted?

There is an example of Inuit children trying to read Dick and Jane. Here are two children, a boy and a girl, who play together, yet the Inuit children know that boys and girls do not play together. Dick and Jane have a dog named Spot who comes in the house. This dog does absolutely no work at all. The mother makes cookies on a stove that has no flame on it. How can she make these cookies? The father goes to work at a place called an office and he never brings any food home with him. The worst of this is yet to come. On the weekend, Dick and Jane drive out to the farm, which is a place where the grandparents are kept. The grandparents are so thrilled to see Dick and Jane that one is certain they must have been ostracized for some terrible reason. Even though they have read the words and maybe answered the questions of what the names of the people and the animals were, their conception of that story was not anything like what our conception was.

Our issues go far beyond what our usual expectations have been as to what we need to do in assessment. The way we have tried to do assessment is that we have one type of shoe and we try to fit everybody into that shoe, regardless. Then we judge that there is some problem with the child. Our ultimate goal of trying to do an assessment to provide the best services for children is not being met by our traditional testing approach.

Elizabeth Pena: I would like to continue the discussion of problems and issues with current assessment strategies and present some of my own work with respect to testing and teaching to discover if a child's language is different or if he or she has a language disorder. I think we are doing quite well at identifying language differences but we are not sure if these differences are also disorders or if these differences are just differences.

One of the problems is that we risk overidentifying children as having disorders when in fact it is just a difference. We also risk underidentifying children who may have language disorders.

Some current problems with assessment strategies are the predictive power of language tests that we use, particularly for younger children. We know that tests do not necessarily predict how children are going to function. We know that language tests with young children do not necessarily predict how those children will perform 6 months later. Therefore, we have limited predictive validity for the tests that we use with young children in general. If one looks at how well those tests predict for children who come from different language and cultural backgrounds, they have even less predictive validity.

We have talked about bias today and I see two different kinds of bias. One is situational bias where the child is not necessarily socialized to the test situation. I am going to be talking a bit more about testing vocabulary because it seems to be a predominant way that we test children's language. One of the vocabulary tests that we use in addition to the Peabody is the Expressive One Word Vocabulary Test. In this test, children are shown pictures and they are asked to name those pictures. We ask, "Do you know what that picture is?" The child knows what that picture is and wonder why we are asking them such an obvious question. That is situational bias. Perhaps they are not necessarily used to this naming game. A stranger comes into the room, takes you to another room, and shows you pictures which are not really drawn well to start with, and you have to tell this person the name of that picture. You are not supposed to tell them about that picture. You are not supposed to tell this person where you can find that object. You are not supposed to tell that person that you have one or what it does; you are supposed to give them the name. So that is the testing situation. If these children have not been playing the naming game, they are not necessarily going to start playing by being put in a room to do this exercise.

We also have psychometric bias. Psychometric bias has to do with the normative sample that is represented in the test norms. The Expressive One Word, which is considered to be relatively valid, reliable, and has a good norming standard, was normed mainly in northern California with about 1200 children. That is a rather large data set, but not necessarily representative of Puerto Rican or African American children in inner-city Philadelphia. If the test norm or the test group does not necessarily represent the child that we are testing, then there is a potential for psychometric bias.

The answer to this issue of bias has sometimes been to locally norm the tests. If one takes the Expressive One Word and renorms it in inner-city Philadelphia, one will have a new set of norms that will be more appropriate for the children in that community, right? Not necessarily, because that situation still may not match the social situations that those children have been used to.

Finally, a criticism of current assessment has been that it is not necessarily linked to intervention. Now that you know that this child is functioning two standard deviations below the mean, what do you do? They are functioning two standard deviations below the mean on a test of single word receptive vocabulary. So we now teach them vocabulary. Or are they not being successful in school? What do you do with that information? Standardized tests are not designed to have that link with intervention but we often try to make that link. They are supposed to do something else in between. Other kinds of assessments are needed to find out what to do next.

I have been looking at some dynamic assessment models. I was working in the San Francisco Bay area as a bilingual psychologist. I was asked to go to several school districts and do assessments of Spanish-speaking children. These preschoolers did not do well on things like colors,

numbers, shapes, and prepositions, even though the test was provided in that child's primary language. One thing I started to do was cue them and then test them after I cued them. However, in many cases, some felt that I could not do that because I would be violating the standardization. The standard test, however, was not necessarily standardized for the group of children with whom we were working. So we were violating the standardization of the test anyway.

The model that I started to use, even though it is very crude and inefficient, was a model of dynamic assessment where we use a test, teach, and then retest approach. What does this help us to do? I believe that it helps us to rule out disorder, or rule out difference and how the spoken words of children can have the clues to the language problems.

We know that there are linguistic variations and socialization variations, but there will still be a child who will score low on a test. We do not necessarily know why that child scored low. We think it could be because of linguistic and cultural variations, but it may be also because they are not good language learners. How can we test whether they are good language learners? By teaching them some aspect of language. Therefore, one of the things that we are trying to do with dynamic assessment is to look at change as a result of intervention, and see if that change is a better predictor of language ability than the static test itself.

The other thing that dynamic assessment potentially helps us do, and I have not done that much work in this area, is help us assist in planning intervention. Hopefully one ends up with a profile that says when a child is given help to pay attention to the words and when the child was told that special names are important because they can help us tell things apart, that helps him or her do better on a test. How does that carry over to classroom learning?

It could be that the time I sat one-on-one with this child was really important. Or, this child had a really hard time when I was talking to him, and so he would get up and find something else to play with. Maybe this child is demonstrating that this task is too hard. Children who are not paying attention and who are having problems following the class get referred for treatment. We need to know what helps or does not help this child.

The other thing that is important to think about is how we think about language and how we think about language assessment. The way that we believe what we believe about language is then going to turn into how we test language and how we evaluate language. What if we believe that language consists of isolated words from a dictionary, not of semantics or grammar or some social interaction? Then one can test each of those separately and have language, right? However, if one puts everything together, one has language. What we are doing in dynamic assessment is looking at language in the cultural context of the child. We then can see the testing situation as a language by culture interaction.

Some children value testing and know that they are being tested. They also know that it is not a game. We also have children whom, when you tell them it is a game, believe that they are playing a game. However, it is really a test. So what I have been doing in dynamic assessment is using the initial test to get a baseline of how these children are doing. What I have found—and this is not a big surprise either—is that many of the children that I have been working with in the Head Start program are testing at about two standard deviations below the test mean. That is very low. A standard score is 70. The question becomes, do we then test at a standard score of 55, three standard deviations lower? sThose must be the children who are very low and who may be going to have some problems. The children who are testing two standard deviations below the mean are also deemed to be having problems.

We have heard from John Baugh and Carol Westby that there are reasons why that is. There are some linguistic differences and specialization differences that are going to cause these variations on test performance. There is still some concern, however, about how these children are doing.

I have been teaching children something about language. What I have chosen to do is to look at vocabulary because it is what we mostly use. When we do any kind of assessment, such as a developmental assessment or language assessment or an IQ test, we do some kind of inventory

of vocabulary. Why do we do that? There are several reasons. First, it is easy to give. Second, it seems to correlate very highly with IQ. Third, we can make some predictions, hopefully, about language development based on a vocabulary inventory. Therefore, one of the things that we have been doing is teaching children about single words. In the Expressive One Word Assessment, if one looks at all of the vocabulary words, all but two are nouns. So we are testing children on a noun-heavy test. Therefore, we have been using intentionality, meaning transcending content, to teach children about vocabulary. Our intent was not to stuff their heads with 100 vocabulary words that they needed to perform better on the Expressive One Word. Although we did try that, but we found that that does not work.

What is it that we are trying to do? When one is teaching a child, one tells him what the goal is. For example, the goal is to work together to learn about labels. We also use mediation of meaning. Here, what we are doing is focusing the child's attention to labels. We know that there are different ways of talking, different ways of communicating, and different ways of naming pictures, or referring to them. Here the idea is that we are teaching them to pay attention to labels. They have been taught to pay attention to functions. They have been taught to pay attention to other things with respect to those pictures. They do not know the naming game and so we are going to say the naming game is important too. What we did is say something such as "Special names help us to tell things apart."

Another component that we are using is transcendence. We bridged what it was that we were learning to other things that were going on in the classroom. What happens in the classroom? The teachers use special names during roll call. If they used a different name and not your special name would you know that they were calling you? No. So we started to bridge what was happening in the test situation to other situations with which they were familiar.

Another component is competence. We help children develop their own plan for how they are going to use labels. A lot of times in teaching we have a plan that we do not necessarily share with them. The idea with helping children plan is to teach them to learn in situations outside of that 20-minute session teaching situation with you.

Another thing that we look at is the issue of modified ability. We looked at three components. The first is examiner effort. When one works with a child and finishes exhausted, that is high examiner effort. There is also low examiner effort where one teaches a child something and the child picks it up immediately. We have created a Likert scale where the clinicians have to judge how much effort they put in to the interaction in order for the child to make a change.

Another component is child responsiveness. Given the level of examiner effort, how responsive is that child? If the examiner has to give the child the answer, or if there is high examiner effort, the child might have different levels of responsivity. Again, we made a Likert scale of child responsivity.

The final component was transfer. If one is looking at a book, labeling, and talking about labels, would the child still know what the goal was when the page is turned? If the material is changed, the book put away, and some cars and trucks are taken out, would the child still know what the goal is? Or would he or she think that now one is doing something else? Is there any kind of indication of transfer?

I conducted a study with Aquiles Iglesias and Rosemary Quinn. We looked at how children performed on various measures. The first measure we gave as a baseline was the Expressive One Word to 60 children. Typically developing children and children with low language ability scored similarly. In fact, there were no significant differences with the mean score of the children with low language ability and the mean score of the typically developing children. What does that tell us? They scored about two standard deviations below the mean. The typically developing mean was about 72 and the low language ability mean was 68. The two groups were very similar.

We also did another task that was the Comprehension Subtest. This is a task that looks at functions. What does one use a stove for? These are things that probably would be more familiar to the group of children that we were testing. These were African American and Puerto Rican

children in the Philadelphia area. We tested the Spanish-speaking children in Spanish. For the most part, they were bilingual, so we tested them in both. What we looked at was a conceptual score. If they said a word in Spanish or English and they were correct, we counted each one as separate on the scores, because what we wanted to do was determine how many labels they have for these various objects. On the description task, there were significant differences between the typically developing children and the children with low language ability, and the typically developing children scored closer to the national norm.

We went back and classified the children according to their score on the descriptive task. Seventy-five percent of the low ability children were classified on this task as having low ability. Therefore, that seemed to be a fair classification. It put 90% of the typically developing children as typically developing. Therefore, classification of children with low language ability did not work as well as the classification of typically developing children. There are still some false positives and false negatives in there.

Next, we did a mediated learning experience with each child in two 20-minute sessions. Their scores were significantly different on the test. The classification was 90% accurate or even better for both the typically developing children and children with low language ability.

Then we went from pretest to posttest with some intervention. The typically developing children increased in their language ability; whereas the children with low language ability stayed the same. This told us that there is something going on in our intervention that helped us to discriminate between children who had language differences but normal language learning ability. We taught them something about language that they could then use and demonstrate fairly efficiently on a posttest. We did analysis of covariance to control for pretest scores. The children with low language ability remained basically the same.

The final thing that we did, which tells me we do not even need these tests, was to look at the three subscales and convert them to standard scores. We found that typically developing children did very well. They had needed low examiner effort and had high responsivity and high transfer. Children with low language ability or language disorders needed high examiner effort and showed low responsivity and not much evidence of transfer. This was the best classification. By itself, it classifies the children about 95% correctly. With the addition of the Expressive One Word posttest, we achieved 100% correct classification.

I really got excited because this was something that was unexpected. In fact, I almost did not use this measure because I was so convinced that the pretest-posttest differences were going to be the answer. I threw in this measure at the last moment. We then went back and looked at effort, responsivity, and transfer. What is going on here? Again, all three were significant and all three classified the children sensitively and specifically.

In a later study, I looked at attention, motivation, and planning. Can we capture child responsivity? The answer seems to be yes. Again, we can use this kind of observation of learning in order to rule out language difference compared to language disorder. This was for two interventions.

There are still some questions to be answered. Does the learning top out at some point? How many interventions do we need in order to tell the difference? With just the first intervention, we started to see the difference between the two groups of children.

I have recently gone back to the two data sets to do some reanalysis of the subcomponents. We looked at attention, motivation, and planning, and found that some things contribute more to the modifiability or to responsivity than other components. So attention, planning, self-regulation, and transfer seem to be significantly different for both children with low language ability and typically developing children, whereas motivation and self-regulation did not differentiate them.

What does this data tell us? My motivation for looking into some of these issues was to find out what is going on. What are some more efficient ways other than trying to understand language development that may not be correctly understood if the test construct does not match

the linguistics and does not match the social context? What is it that we can do on an individual basis to rule out language difference from language disorder?

Elizabeth Sulzby: I have had a real education at this conference the last few days. I am very grateful to our presenters today for bringing these issues to the forefront.

For the last year, I have been a teacher's assistant in a Head Start program that serves an African American community in Detroit. Sally Lubeck has just started working in a Head Start program that we will be moving to next year that serves a community that was a long-time Polish community in Detroit. There are now 26 different languages in the community and 11 languages in the Head Start program where we will be working.

I am also working in Chicago in a Spanish-English bilingual district, kindergarten through grade 8 as part of the new Center for the Improvement of Early Reading Abilities. Therefore, these topics are of intense interest to me. However, I am hearkening back to my days as a reading specialist and an ESL teacher in the public schools and then transferring this to the Head Start context that I see in Detroit. I am going to address the day-to-day tasks of working with children and also try to relate some of these points to issues that I see with children.

First of all, I ask what kinds of testing actually go on in Head Start programs? It is very clear that there is the kind of testing which we heard a fair amount about today, which is the testing for services or for identification, especially the speech and language identification to which Elizabeth Pena was pointing.

I have had the good fortune in the last 4 years to be working with a young woman who did a NIH post-doc with me who is a speech language pathologist. We have done some work in homes of children where parents were doing repeated storybook reading and repeated toy play with children who were identified as specifically language impaired and with typically developing children. She has given me an intensive look into the kinds of testing that speech and language pathologists do. That is a kind of testing that certainly goes on in Head Start programs, but does not necessarily get translated to the classroom providers in the kind of detail and depth that Elizabeth Pena was discussing with us. I want to come back to the issue of how we can make that communication better.

There is certainly also the kind of assessments that teachers do that leads to classroom or center evaluations. How well are we doing with all of our children? Where are the problem areas with our children? How well are we meeting federal guidelines and how are we communicating to the various regulatory systems?

The most important assessment, it seems to me, is the assessment that goes on for day-to-day teaching and care of the children and for communication with parents and other caregivers. Here, all three of the papers were very relevant to those kinds of issues, but at a very sophisticated level. My concern is how we can take this important material and translate it and communicate it to teachers and parents in Head Start centers.

For the last 2½ years, another part of my life has been serving on the National Academy of Sciences' National Research Council (NASRC) Committee on the Prevention of Reading Difficulties in Young Children. A number of the recommendations coming out of that report are very relevant. One recommendation is for extended discourse in Head Start classrooms, which was something I saw very little of this last year. There should be conversations with children that take place over time and situations in which children are allowed to tell extended stories or to take part in extended discourse with peers and with teachers.

Carol Westby's work alerting us to the differences in what is expected in children's homes and communities about extended discourse is extremely relevant. It is not only extended discourse in the Head Start classrooms that is important, but also an analysis of risk factors. One of the strongest risk factors is a child with early language disorders. I was so glad that a number of the presenters today talked about the problem of overdiagnosis and underdiagnosis. However, we did not talk today about some work that my colleagues Julie Washington and Holly Craig have

done. They found that African American boys are often overidentified as having language disorders because they used more complex syntactic structures that included features of African American vernacular English. The problems of testing young children extend not just to problems of testing young children, but testing young children in all of their variations, both linguistic and cultural. I was glad that John Baugh talked about the informal and formal shifts within standards of dialect.

I was the child of parents who had a little bit more education than most in the coal-mining town in rural Alabama where I grew up. When I started elementary school, they called me, "That little girl who talks proper." Very quickly I had to learn how to talk right. I got so I could say, "I ain't got none" quite easily. If I did not, I would have been ostracized socially. I think that is probably what led me to such an intense interest in linguistics, linguistic variation, and its effect upon children.

Children who are identified early by their teachers as having difficulties and who receive services at a very young age are culled out and identified by themselves and their peers as having difficulties. I am concerned about the importance of consultants who come into classrooms to help classroom teachers understand what they can do in the classroom so children are not singled out.

Now there is the issue of oral language. However, Carol and John pointed to something that we often do not necessarily pay attention to at the Head Start level. That is the relationships between oral and written languages that take place in the oral context for 3 and 4-year-old children.

My own research is in emergent literacy. A second finding of the NASRC report was the recommendation that we provide rich emergent literacy experiences for young children in early care centers, and that we provide extensive training for the teachers in these centers about how literacy develops for very young children. That is not just in the area of phonemic awareness and helping children rhyme and chant and so forth. It also extends to reading books to young children, encouraging children to read back in their own way, encouraging children to take up pencil, crayon, and marker and do writing their own way, and read back from that writing.

However, we certainly do not know enough about the oral-written language relationships in the cultures and the languages that our children come from in order to translate that to make sense of it to teachers. For example, some children for whom extended discourse is not encouraged would be overidentified using naturalistic samples of their language, if one did not understand that. I think that point came through loud and clear today.

Regarding the questions about assessment, I can make some practical points about how this has played itself out in Head Start and I will try to weave those in. I do want to get to the issue about assessment itself, though. Who does the assessment? Is it the classroom teacher doing it, and with what kind of training? Is it the specialist who does it, and with what kind of training? How up-to-date are they? Many school psychologists and school social workers also do not have a background in early literacy development or even an intensive background in oral language development, bilingualism, multilingualism or the degrees to which children are English language learners and competent in English.

I will give you an example of a child in Chicago. I am in a Spanish-English bilingual district that is urban and blue-collar. The socialization practices there were clear. I worked with 120 kindergarten children where almost all of the young men opened doors for me and treated me with the greatest respect. I was shocked at the consistency of this behavior until I went in to get a youngster who was flirting with a classmate as he left his kindergarten classroom. The classmate was saying, "Hurry back." I took a look at him, did a quick sizing up, and thought, "This is another culture I have here." As we were going down the hall, I asked, "So, is she your girlfriend?" He said, "No, she dumped me." I said, "How come?" He said, "Well, I don't know if I did something wrong or if she done something wrong." I was hearing a teenage voice come out of this little child's voice and body. So we chatted down the hall. We came in and we started the

session in which I elicited an oral narrative from him. That was no problem because he was just full of himself and told me everything under the sun. Then we started talking about the particular book that his teachers read to him repeatedly. He told me his favorite parts and showed me he comprehended it. Then I said, "Well, read me your book. It does not have to be like grownup reading; just read it your own way." He started reading the book and then suddenly this child who never, to my knowledge, knew my first name—this is not a district where first names are used— looked up at me and said, "I don't know that word, Elizabeth." He addressed me by my first name and indirectly elicited the word. I did not notice it. It was the person watching the videotape who later said, "I never heard a child here talk like that." It just popped out at you just exactly like that.

To someone assessing a child's language who was not paying attention to the social conventions or who was not paying attention to how that child would stand out in that district, his language and behavior might not look like a problem at all. In his classroom, I suspect he there are some social problems, such as fitting in and getting along with the other children.

There is a question of being up-to-date. Somehow we think that that would not matter too much. I have heard very important information about issues of bilingualism and multilingualism that many of the people who administer tests will not know.

Here is another issue that concerns me and that we can do something about. I was trained to give individual intelligence tests. I was trained by a real stickler. He said that the state of Virginia has no standards of how many administrations of a test one gives, how many are observed, and how many one reports on. However, he took us through the wringer on standards of test administration, dealing with issues of rapport and talking about the findings in a way that is understandable to other people, such as the limitations of how one gave a test, the child's responses, and some of the issues that would go beyond the test itself.

One cannot get by with that kind of report in public schools or Head Start programs. One does not write reports like that. That is too much information. Yet, that is exactly the kind of information that we need to have. My point here is how can we help consumers address these issues? How much do consumers tolerate and/or request the best thinking from people who give tests and their best explanation about the child's performance and the conditions under which the child was working?

I think that that is a policy issue and a practice issue about which we can do something. We can say to speech and language pathologists, social workers, and school psychologists, "Tell us more about how that test went. Tell us what you know about that child's family and linguistic background: how you think that child was reared, and how that affects your interpretation of the test." In addition, we can support, request, and urge all people who give tests or who do informal assessments to learn more and more about these issues.

I am going to stop with a quotation from one of the presenters today. I think Aquiles Iglesias started us out with the "It ain't the Peabody, honey" kind of quotation that I misinterpreted, but the statement that one of our presenters made is that, "Translation is not the issue. Translation is not the solution. Translation can, though, shed some lights on some issues."

A few weeks ago we were doing Spanish-English assessment and we needed to have a phonemic awareness test and we did not have one in Spanish. We were trying to get hold of Holly Yopp to get the version that she is working on, could not get hold of it, and bypassed others that we did not think were appropriate for our particular population. Suddenly, Sunday afternoon it came down to fish or cut bait. I, with my limited proficiency in Spanish, created a phonemic awareness test that had words that were approximate to Yopp's words for segmentation and blending. They are all one syllable words. If one knows Spanish, one knows there are not a lot of one syllable words. Then if one thinks about what function those words have and how they are going to stand out in children's experience, it is a miserable kind of task to do.

Well, it turned out we got Yopp's test, and here is where the translation came in. Because of the limitation of how many eligible words there were for that kind of task, we overlapped by

about two thirds of the words. On the words where we differed, I had been weighing the same kind of issues of choice of words as she had. It was not important that there was commonality; the issue was that they were inappropriate words to begin with to deal with phonemic awareness in Spanish. It ain't the translation. It is the thinking that goes into it. I applaud our paper presenters today for having taken us quite deeply into some issues that I think we can translate into good practice.

Question: It occurred to me as you were speaking about the mediated learning experiences in helping children, that most of those things that you were doing, the motivation, intentionality, and the self-regulation are things that a good Head Start teacher should do throughout the year. Would it make sense to delay doing speech and language assessments until later in the year after the child has been, in a sense, more acclimated to mainstream teaching?

Pena: I want to say yes on the one hand, but it would require that those strategies be observed. The teacher would have to use mediated learning experiences (MLE) in teaching and be aware of what the mainstream expectations were for later schooling. She would then have to use components of mediated learning too in her teaching throughout the year. Then I think it could work. We tried doing that for a year in a Head Start preschool. We received a small grant in a San Francisco Head Start, and teachers had varying degrees of experience in MLE. Some of them were very familiar with what mainstream expectations would be later on. Some of them had ideas of what those experiences would be, but they really did not know.

We found that they were using stories and telling stories in the classroom, but had a different purpose in mind about teaching narrative discourse. They were teaching children to sit down and be quiet and to pay attention, which is going to be an expectation of later schooling, but that is not why we think we are doing story time. So it would require a certain level of training, but I think it certainly would work.

Question: My question has to do with the issue of bilingual learning. Many Head Start programs are working with children who are monolingual in their homes. We know that language is in the context of the culture in which they are raised. Acknowledging the difficulty that we have within our programs in providing the kinds of languages and language experiences within the classrooms that will help children to be effective communicators and so forth, how do we prepare our teachers for this experience?

Sulzby: Maybe I can say a few words, not an answer to that, but about an effort we are mounting. I mentioned the work that we are doing in Detroit in a center that has 11 languages in the center. We are working under the framework of a parent/teacher research collaboration to start having conversations with parents and other community members as informants to try to help us understand. In some communities, however, the issues are whether there are storybooks for children or whether there is a storybook culture. What kinds of things are done in the home and in the community that we could bring into the Head Start program to extend what parents are doing? It is a matter of all of us puzzling, studying, talking together, and gaining information.

Iglesias: I hope that the presentation was stimulating and that it at least made you think differently. Every time I hear John Baugh or Carol Westby or Elizabeth Pena talk about their work—especially Carol because she has worked with a population very different from mine—I keep wondering if I am being culturally sensitive or whether I have been violating all of these rules. I think that is the part of me that feels good when I am uncomfortable about what I am doing. I hope you feel that too. It sounds like an odd way of living, but it is a good way because I think that the only way things are going to change is when we question some of the things that are currently accepted practice.

New Measures of Mastery Motivation for Infancy Through Elementary School

CO-CHAIRS:: George A. Morgan, Nancy A. Busch-Rossnagel
DISCUSSANT: Nancy A. Busch-Rossnagel
PRESENTERS: Diana E. Knauf, David MacPhee, George A. Morgan

Mastery motivation is an inherent force that stimulates exploration of the environment and mastery of moderately challenging skills. It is the impetus to achieve and improve one's skills in the absence of any physical reward (Busch-Rossnagel, 1997). No doubt mastery motivation is a precursor of achievement motivation, and mastery motivation has been found to be more predictive of later competence than developmental tests (Messer, McCarthy, McQuiston, MacTurk, Yarrow, & Vietze, 1986).

Historically, mastery motivation has been studied primarily with object-oriented tasks developed for children age 6 months to 3 years. Persistence at object-oriented tasks has been the main way of operationalizing the concept (MacTurk, Morgan, & Jennings, 1995). In recent years, the construct and associated measurement efforts have expanded in several ways. First, in addition to the instrumental aspect of mastery motivation, attention has been paid to the expressive aspect, termed mastery pleasure. Mastery pleasure is assessed through expression of positive affect during task-directed behavior and/or immediately after a solution. This aspect has been tied to work in socioemotional development, such as the expressions of pride and shame (Barrett & Morgan, 1995).

Related to the work on the instrumental and expressive aspects of mastery motivation is the expansion of the concepts and the measures to include multiple domains. These domains include object-oriented or cognitive tasks, social interactions, and gross motor/athletic skills. The concept of social mastery motivation expands the focus of mastery from the inanimate objects in the environment to interactions with people, while the gross motor area focuses on an area of individual achievement. The toddler study described in this symposium used social tasks and the school-age study used motor tasks.

A third area of expansion involves the development of both paper and pencil and observational measures. For the observational measures, Morgan, Busch-Rossnagel, Maslin-Cole, and Harmon (1992) developed an individual method of presenting tasks to toddlers that assesses each child on tasks determined to be moderately challenging for that specific child. This method allows the separation of motivation from competence and allows for use of the measures with special needs or low-income samples, including those in the toddler and preschool studies reported here.

The Dimensions of Mastery Questionnaire (DMQ; Morgan, Maslin-Cole, Harmon, Busch-Rossnagel, Jennings, Hauser-Cram, & Brockman, 1993) is a parent/teacher report questionnaire designed to measure several aspects of mastery motivation in young children and provides a briefer, less expensive assessment of the child's functioning than that gained from observational tasks. In 1995, we revised the DMQ for preschool children and, using the method of decentering, equivalent Spanish and English versions were created.

A final expansion has occurred in the age groups studied starting with infants as young as 6 months and continuing to 12 years. This expansion of measures to new age groups sets the foundation for future longitudinal studies of the developmental changes in mastery motivation and of relationship of mastery motivation to achievement motivation, perceived self-competence, and academic achievement. Work with school-aged children, both on the development of instruments and on the relationship to perceived self-competence and intrinsic motivation, is the focus of the final paper.

References

Barrett, K. C., & Morgan, G. A. (1995). Continuities and discontinuities in mastery motivation during infancy and toddlerhood: A conceptualization and review. In R. H. MacTurk & G. A. Morgan (Eds.), *Mastery motivation: Conceptual origins and applications.* Norwood, NJ: Ablex.

Busch-Rossnagel, N. A. (1997). Mastery motivation in toddlers. *Infants and Young Children, 9,* 1–11.

MacTurk, R. H., Morgan, G. A., & Jennings, K. D. (1995). The assessment of mastery motivation in infants and young children. In R. MacTurk & G. A. Morgan (Eds.), *Mastery motivation: Origins, conceptualizations, and applications.* Norwood, NJ: Ablex.

Messer, D., McCarthy, M., McQuiston, S., MacTurk, R., Yarrow, L. J., & Vietze, P. (1986). Relation between mastery behavior in infancy and competence in early childhood. *Developmental Psychology, 22,* 366–372.

Morgan, G. A., Busch-Rossnagel, N. A., Maslin-Cole, C. A., & Harmon, R. J. (1992). *Individualized assessment of mastery motivation: Manual for 15- to 36-month-old children.* Unpublished document, Fordham University.

Morgan, G. A., Maslin-Cole, C.A., Harmon, R. J., Busch-Rossnagel, N. A., Jennings, K. D., Hauser-Cram, P., & Brockman, L. M. (1993). Parent and teacher perceptions of young children's mastery motivation: Assessment and review of research. In D. Messer (Ed.), *Mastery motivation in early childhood: Development, measurement, and social processes* (pp. 109–131). London: Routledge.

■ Toddler's Mastery Motivation and Maternal Expectations: Urban Puerto Rican and Dominican Mothers and Children

Diana E. Knauf, Wendy Bobadilla, Nancy A. Busch-Rossnagel

Mastery motivation promotes competence (Barrett & Morgan, 1995) and is believed to be the precursor to achievement motivation (Dweck & Elliott, 1983). While mastery motivation is conceptualized as an internal drive, it is not immune to environmental influence. Maternal expectations for child development are reflected in the childrearing practices she employs, and these expectations are influenced by socialization goals valued in the mother's culture. Latinos attain low levels of education and show low levels of achievement motivation (Nielsen, 1986). Our goal in this study was to investigate possible contributors to these low levels of academic achievement and motivation by relating maternal expectations to mastery motivation in low-income Dominican and Puerto Rican toddlers.

Forty-seven (35 Puerto Rican and 12 Dominican) low-income mother-child dyads participated in the study. The mean age of the mothers was 28.34 years and the average education level was 12 years. The majority were United States-born (53%, n=26). The 22 boys and 25 girls fell into three age groups: 16 months old (n=14), 19 months old (n=18), or 22 months old (n=15).

The Dimensions of Mastery Questionnaire (DMQ; Morgan, Maslin-Cole, Harmon, Busch-Rossnagel, Jennings, Hauser-Cram, & Brockman, 1993) is a maternal report measure of mastery behaviors using a 4-point Likert scale. Thirteen items from the Individualism-Collectivism measure (INDCOLL; Hui, 1988) were used to assess mothers' cultural orientation. Maternal socialization goals were assessed using a revised Child Development and Skills Questionnaire (CDSQ; Vargas, 1996). The Maternal Expectations Assessment measure (MEA; Bobadilla, 1998) assessed the desirability of certain child behaviors. Both Spanish and English versions of these instruments were developed using the process of decentering. Forty-three percent of the sample chose to complete the measures in Spanish. Children completed two mastery tasks: a puzzle and a shapesorter (Morgan, Busch-Rossnagel, Maslin-Cole, & Harmon, 1992).

Mothers rated DMQ persistence items as somewhat typical of what their children do at home. With moderately difficult structured tasks, children exhibited persistence approximately half of the time, which is comparable to past research. Mothers reported that children typically

show pleasure while engaged in mastery tasks at home while low levels of pleasure were observed during the structured tasks.

On the CDSQ, mothers expected politeness and compliance from children at about age 2, emotional maturity and social skills by age 3, and verbal assertiveness by age 4. The Maternal Expectations Assessment measure results indicated that mothers found appropriate social behavior to be the most important, followed by conformity to social norms and independence. Cultural orientation scores indicated that participants were more collectivistic than individualistic in their cultural orientation. Correlational analyses revealed no significant correlation between mastery motivation variables and maternal education or expectation for children. Expectations for compliance, politeness, and social skills were negatively correlated with maternal educational level. Number of adults in the household was negatively related to CDSQ expectations.

These children exhibited comparable levels of mastery motivation to that shown in past research. Unfortunately, relationships between mastery motivation variables and maternal characteristics and expectations were not confirmed for this sample. This finding is discussed in relation to the difficulty of preparing cultural sensitivity measures of mastery motivation.

References

Barrett, K. C., & Morgan, G. A. (1995). Continuities and discontinuities in mastery motivation during infancy and toddlerhood: A conceptualization and review. In R. H. MacTurk & G. A. Morgan (Eds.), *Mastery motivation: Conceptual origins and applications.* Norwood, NJ: Ablex.

Bobadilla, W. (1998). *Assessing Latinos' cultural values through the expected behaviors of their children: The Maternal Expectations Assessment Measure.* Unpublished document, Fordham University.

Dweck, C. S., & Elliott, E. S. (1983). Achievement motivation. In P. H. Mussen (Series Ed.) & E. M. Hetherington (Vol. Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (4th ed., pp. 645–691). New York: Wiley.

Hui, C. H. (1988). Measurement of individualism-collectivism. *Journal of Research in Personality, 22,* 17–36.

Morgan, G. A., Busch-Rossnagel, N. A., Maslin-Cole, C.A., & Harmon, R .J. (1992). *Individualized assessment of mastery motivation: Manual for 15- to 36-month-old children.* Unpublished document, Fordham University.

Morgan, G. A., Maslin-Cole, C. A., Harmon, R. J., Busch-Rossnagel, N. A., Jennings, K. D., Hauser-Cram, P., & Brockman, L. M. (1993). Parent and teacher perceptions of young children's mastery motivation: Assessment and review of research. In D. Messer (Ed.), *Mastery motivation in early childhood: Development, measurement, and social processes* (pp. 109–131). London: Routledge.

Nielsen, F. (1986). Hispanics in high school and beyond. In M. A. Olivas (Ed.), *Latino college students.* New York: Teachers College Press.

Vargas, M. (1996). *An adaptation of the Child Development and Skills Questionnaire for Hispanics.* Unpublished document, Fordham University.

■ Assessing Mastery Motivation in a Head Start Sample

David MacPhee, Janet J. Fritz, Jan Miller-Heyl

Research on the early identification of at-risk learners shows that preschool tests do not predict later success as well as the ability to follow directions and systematically approach tasks (Rogers & Webster, 1987). Individual assessments of mastery motivation are too time consuming for screening purposes so we examined whether a parent-report measure, the Dimensions of Mastery Questionnaire (DMQ; Morgan, Maslin-Cole, Harmon, Busch-Rossnagel, Jennings, Hauser-Cram, & Brockman, 1993), might be valid for Head Start parents. We also studied its

relation to individually administered mastery tasks and childrearing practices, hypothesizing high mastery motivation is related to encouraging autonomy and nonauthoritarian parenting.

Head Start children and their families were recruited from rural communities in Colorado. The sample was 10% Hispanic, 36% American Indian, 35% White, and 19% other. Some families were enrolled in parent/child workshops. Although we have found DMQ scores to improve as a result of the intervention, this study focuses on the pretest assessments.

Caregivers completed a battery of questionnaires that included: (a) four scales from the DMQ, (b) the Social Skills Rating System (Gresham, 1986), and (c) three different measures of childrearing practices such as limit setting, granting autonomy, harsh punishment, and causal attributions. The children were given a developmental inventory and a series of mastery tasks adapted from Jennings, Yarrow, and Martin (1984), and Jennings, Connors, and Stegman (1988) such as a curiosity box, puzzles, and a magnetic fishing game. Goal-oriented and off-task behavior, bids for help, prompts, success in solving tasks, and preference for challenge were coded. Examiners also rated the children's task orientation and affect regulation.

The data show the DMQ to have adequate test-retest and alpha reliabilities. Mother-father agreement was high for the persistence scales but was low for the other scales. In a factor analysis, the motor and object-oriented items formed distinct factors, items from the persistence-in-play scales (adult, peer) formed one factor, and the fourth factor was comprised of items on giving up easily or avoiding challenges.

The mastery task scores yielded a single bipolar dimension of goal orientation, which was correlated with examiner ratings of task orientation but not preference for challenge. The DMQ was unrelated to mastery task scores and examiner ratings of task orientation. However, DMQ scores were correlated with parent reports of the children's social skills, suggesting that the DMQ is related to children's cooperation and assertiveness.

Contrary to our hypothesis, granting of autonomy was not related to goal-directed behavior nor to preference for challenge. Children of authoritarian parents were less confident, more dependent, and less object oriented in mastery situations. These results suggest that the DMQ is a reliable measure, but it does not correspond well to direct observations of mastery motivation. Instead, the DMQ was more strongly related to parent ratings of children's social skills. Thus, the two types of measures seem to tap different constructs, although both are related to authoritarian parenting.

References

Gresham, F. M. (1986). Conceptual and definitional issues in the assessment of children's social skills: Implications for classification and training. *Journal of Clinical Child Psychology, 15*, 3–15.

Jennings, K. D., Connors, R. E., & Stegman, C. E. (1988). Does a physical handicap alter the development of mastery motivation during the preschool years? *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 312–317.

Jennings, K. D., Yarrow, L. J., & Martin, P. P. (1984). Mastery motivation and cognitive development: A longitudinal study from infancy to 3½ years of age. *International Journal of Behavioral Development, 7*, 441–461.

MacTurk, R. H., Morgan, G. A., & Jennings, K. D. (1995). The assessment of mastery motivation in infants and young children. In R. H. MacTurk & G. A. Morgan (Eds.), *Mastery motivation: Origins, conceptualizations, and applications.* Norwood, NJ: Ablex.

Morgan, G. A., Maslin-Cole, C. A., Harmon, R. J., Busch-Rossnagel, N. A., Jennings, K. D., Hauser-Cram, P., & Brockman, L. (1993). Parent and teacher perceptions of young children's mastery motivation: Assessment and review of research. In D. Messer (Ed.), *Mastery motivation in early childhood: Development, measurement, and social processes* (pp. 109–131). London: Routledge.

Rogers, J. G., & Webster, R. E. (1987). *A research review of early identification of at-risk learners.* ERIC Document ED326–299, online resource.

■ Assessing Mastery Motivation in 7- and 10-Year-Olds

George A. Morgan, Sheridan Bartholomew

The purpose of this study was to examine the construct validity of two types of measures of mastery motivation, the Dimensions of Mastery Questionnaire (DMQ; Morgan, Maslin-Cole, Harmon, Busch-Rossnagel, Jennings, Hauser-Cram, & Brockman, 1993) and behavioral mastery tasks, by examining the relations among them and relations to selected scales from Harter's self-perceived competence and intrinsic motivation measures.

The 64 participants were mostly middle class and Caucasian, living in a middle-sized city in the Rocky Mountain West. The sample consisted of 31 boys and 33 girls; there were 34 7-year-olds and 30 10-year-olds.

Four types of measures were used. First, mothers and teachers rated the children on the DMQ (Morgan, Bartholomew, Barrett, Busch-Rossnagel, Knauf, & Harmon, 1998; Morgan, et al., 1993). The five DMQ mastery motivation scales (persistence at tasks in the cognitive, gross motor, social with peers, and social with adults domains, and mastery pleasure) were also administered orally to the children. Internal consistency of these scales was very good for mothers and teachers; alphas ranged from .82 to .92. For the children, alphas ranged from .61 to .81, with a median of .70. Factor analysis for large groups of parents and of children/teens support the grouping of items into these five mastery domains. Scale scores for these domains are moderately related; thus, total persistence and total mastery motivation scores were also computed.

The second type of measure (Bartholomew & Morgan, 1997) was based on observations of behaviors on four sets of mastery tasks (complex puzzles, Tower of Hanoi, fine motor, and ring toss). Each set had five levels of difficulty, varying from an easy level that all 7-year-olds could solve in 1 minute, to a very hard level that no 10-year-old could solve in 5 minutes. Each child was given a task from each of the four sets that was relatively easy for them in order to provide a sense of accomplishment. Then the child was given a level of the task somewhat too hard for him or her to fully complete in 5 minutes. Measures included the duration of the children's persistence at each hard task and ratings of their mastery pleasure.

In addition, three of Harter's (1982) self-perceived competence scales (scholastic, athletic, and peer acceptance) answered by mothers and children, and two of Harter's (1981) intrinsic verses extrinsic orientation in the classroom scales (preference for challenge and independent mastery) were rated by the teacher and child.

There were few significant gender or age differences, except 10-year-olds were more competent at the tasks. Intercorrelations among the three raters (mothers, teachers, and children) on the DMQ were modest (ranging from .06 to .59, median .30). Perhaps they have somewhat different perceptions because they view the child in different contexts. Correlations of the DMQ with similar Harter measures, for the same rater and across raters (e.g., parent DMQ and teacher Harter) were mostly significant. Finally, significant, but modest correlations were found between the child's persistence at the tasks and their persistence self-ratings on the DMQ. Thus, there is some support for both the DMQ and the tasks as valid measures of mastery motivation.

References

Bartholomew, S., & Morgan, G. A. (1997). *School-aged home visit procedures and scoring manual.* Unpublished document, Colorado State University.

Harter, S. (1981). A new self-report scale of intrinsic versus extrinsic orientation in the classroom: Motivational and informational components. *Developmental Psychology, 17,* 300–312.

Harter, S. (1982). The perceived competence scale for children. *Child Development, 53,* 87–97.

Morgan, G. A., Bartholomew, S., Barrett, K. C., Busch-Rossnagel, N. A., Knauf, D. E., & Harmon, R. J. (1998). *An update on the Dimensions of Mastery Questionnaire.* Unpublished document, Colorado State University.

Morgan, G. A., Maslin-Cole, C. A., Harmon, R. J., Busch-Rossnagel, N. A., Jennings, K. D., Hauser-Cram, P., & Brockman, L. (1993). Parent and teacher perceptions of young children's mastery motivation: Assessment and review of research. In D. Messer (Ed.). *Mastery motivation in early childhood: Development, measurement, and social processes* (pp. 109–131). London: Routledge.

Research-Practitioner Partnerships and Collaborations

Poster Forum: Innovative Models of Professional Development and Training

CHAIR: Karren Wood
DISCUSSANT: Carol Seefeldt
PRESENTERS: Karren Wood, Joyce Rawlings, Marian H. Jarrett, Doris McNeeley Johnson, Penelope J. Wald, Holly Blum, Terri McFadden-Garden, Ann Hazzard, Marianne Celano, Ruth Kaminski, Beth Stormshak, Roland Good, Mark Shinn, Edward Feil, Maureen A. Nalle

■ Teaming as a Support for Professional Growth

Karren Wood, Angela Branch

Change in educational programming is difficult to accomplish in stable programs. The culture of child care and early childhood education professionals is buffeted by many issues, and tolerance for change is limited (Helburn, 1995). Grappling with high staff turnover, directors with little, formal administrative experience, jeopardized financing, and little respect from the field of special education, community-based early childhood programs are striving to serve children with disabilities. They are looking for support, information, and resources.

The Community Connections Project was committed to supporting early childhood and child care personnel in their collaboration with other service providers and community programs to meet the needs of all children in inclusive settings. It was grounded in the belief that children with disabilities should have the option of attending community programs with their nondisabled peers. Past experience had shown that early childhood and child care personnel were capable of providing and maintaining quality early childhood programs for a diverse group of children. Accepting the challenge of change for inclusion is best approached by teams (Briggs, 1997).

This federally funded special project developed and implemented a tri-state model of in-service training with accompanying instructional materials. The innovative model met the needs of early childhood personnel and programs for specific information and ongoing support in serving children with disabilities. Teachers, administrators, and parents became knowledgeable about the laws related to children with disabilities, working with families and children, inclusive practices, and training skills. It afforded career advancement through the earning of university credits. Participant teams came to the university from early childhood programs and were educated, supported, and mentored in a "team-conscious" environment.

All participants examined their personal values about inclusion and developed a philosophy and mission statement for their team to guide their self-determined action plan for inclusion. Facilitated team activities and specific group assignments between classes gave them experience

with the teaming process. Consultation and on-site support were available from project staff. Working together as a team was a focus and a support as the participants became resources in their communities and developed presentations for national, state, and local conferences. The teams attributed much of their success to working collaboratively.

The use of teaming as a support of program efforts is not common to early childhood and child care program practice. The successful introduction of this change in this environment requires an understanding of the forces affecting quality programming in early childhood programs. The Head Start team featured serves a rapidly changing African American and immigrant population. Four individuals take a journey that moves them from separate roles, separate locations, and individual viewpoints to become a cohesive training team with a vision for improving the lives of their families and children. How they collaborate to develop the skills for training will be described and shared with the audience.

References

Briggs, M. H. (Ed.). (1997). *Building early intervention teams: Working together for children and families.* Gaithersburg, MD: Aspen Publishers, Inc.

Helburn, S. (Ed.) (1995). *Cost, quality, and child outcomes in child care centers. Technical report.* Denver, CO: Center for Research in Economic and Social Policy.

■ Staff Development in a Community-Based Research Project

Marian H. Jarrett, Doris McNeeley Johnson

Summary not available at time of publication.

■ Project REALIGN: Engaging Schools in Collaborative Learning

Penelope J. Wald, Holly Blum

Project REALIGN is a school-based staff development model designed to enhance collaboration among staff from multiple disciplines. Project REALIGN is a federally funded model, in-service training project sponsored by The George Washington University Department of Teacher Preparation and Special Education in partnership with the Fairfax County Public Schools Department of Student Services and Special Education and the Instructional Services Department. The purpose of Project REALIGN is to enhance the capacity of elementary school multidisciplinary teams to explore and implement collaboratively new strategies for meeting children's diverse educational needs.

REALIGN is based on the belief that collaborative learning among staff from diverse roles, grade levels, and disciplines is a key step toward creating programs that address the diverse needs of all learners. As professional communities learn to listen to and act on the diverse perspectives of teachers, specialists, paraprofessionals, administrators, and parents, new knowledge and practices emerge that embrace the diversity of the children being served.

In Project REALIGN, staff, administrators, and parents join together to identify and pursue goals that are meaningful to their school community. Each participant is an active member of a "learning" team that engages in an in-depth exploration of a topic that has personal significance and relevance to the school. Over the course of a year, staff articulate common goals and aspirations for children, explore core values and beliefs, and work together to improve practices.

This process deepens the capacity of a school's staff to become collaborative learners who appreciate and capitalize on the unique perspectives of each individual.

Approximately 150 staff from four elementary schools in the Fairfax County Public Schools piloted the REALIGN collaborative learning process. Participants represented the diversity of roles, for example, teachers, paraprofessionals, administrators, specialists, and therapists, and range of programs, for example, general education, special education, ESL, and Head Start, offered in the schools. The evaluation model assessed the degree to which the collaborative learning process enhanced the capacity of participants to: (a) create instructional practices responsive to the needs of all children, (b) increase opportunities for children with disabilities to be active members of the school community, and (c) build knowledge and skills in professionally meaningful areas.

Final evaluations and retrospective interviews provided the qualitative data for this report. The following findings regarding the impact of the collaborative learning process emerged from the synthesis of the qualitative data. The participants reported:

1. An increased sense of personal confidence as demonstrated by: (a) an enhanced understanding of classroom strategies and underlying theories, (b) an increased opportunity for participatory leadership, and (c) less hierarchical distinctions among staff;
2. Expanded competencies in inclusive practices as a result of (a) opportunities for research and experimentation, and (b) the allocation of time and resources for team learning;
3. New relationships among parents and staff from multiple disciplines and grade levels, both within and outside of their school building; and
4. The need for continual monitoring and adjusting of school infrastructures to support the collaborative learning process.

■ Evaluation of an Emergent Literacy Training Curriculum for Pediatric Residents

Terri McFadden-Garden, Marianne Celano, Ann Hazzard, Trish Melhado, Sharon Dabrow
PRESENTER: Terri McFadden-Garden

Physicians are often the primary source of information for parents who want guidance regarding reasonable expectations for their child's development (MacPhee, 1984). However, studies have found that pediatricians may not always be adept at responding to parents' questions about developmental issues (Costello, 1986). Emergent literacy is an area of development that has recently received attention in pediatric training and practice (Needlman, Fried, Morley, Taylor, & Zuckerman, 1991). Children's reading ability is critical to their future academic success (Olson, Torrance, & Hildyard, 1985). Parents can play an important role in encouraging the development of emergent literacy skills by their children, but they may need guidance about how to best foster their children's skills in this area. Pediatricians have a unique opportunity to encourage behaviors that improve children's literacy, as they are often the only childhood professional in contact with families prior to school entry. This study presents the evaluation of a program that teaches pediatric residents to intervene in emergent literacy during the routine child health visit.

The primary goal is to determine whether training in emergent literacy-building techniques increases self-reported literacy-related knowledge and attitudes of pediatric residents. The subjects are pediatric residents from two training programs in the Southeast. The residents provide pediatric care in one of three outpatient clinics, all of which serve ethnically diverse, low-income families. Site 1, located in Florida, has an intervention group, Clinic A, consisting of 34 residents who received the training and a control group, Clinic B, consisting of 20 residents

who did not receive training. The second site, located in Georgia, consists of Clinic C, where 15 residents received the training.

All residents completed pretests of demographics and literacy-related experience, knowledge, and attitudes. The authors developed knowledge and attitudes measures to assess: (a) knowledge about early literacy milestones and appropriate parent-child activities to encourage early literacy-skill development, and (b) attitudes about the importance of literacy assessment and related anticipatory guidance within a pediatric clinic. In the 2 months following the pretests, the intervention groups received 1 hour of literacy training designed to teach residents: (a) the relationships among language, literacy development, and academic success, (b) to conduct assessments of preschool patients' literacy milestones, and (c) to give literacy-related anticipatory guidance to parents of preschoolers. For the next 6 months, children's books and brochures for parents were available in each exam room used by the trained residents. The trained residents also had access to give-away books and were encouraged to give one to each patient in the targeted age range (6 months to 5 years old). Residents in the control group received no specific training on emergent literacy.

Six months after the training, all residents completed a knowledge and attitude assessment in addition to a self-report measure of their practice related to emergent literacy (e.g., the estimated percentages of patients who received a literacy-related assessment). There were no significant differences between the two sites on pretest knowledge or attitude scores; thus, data from the sites were combined for the pre-post analyses. Analysis of covariance will determine whether training resulted in differential gains in knowledge and attitudes. Chi-square analyses will determine if self-reported practice variables differ according to the training condition. We hope to demonstrate that training in emergent literacy significantly improves resident knowledge and attitudes in this area.

References

Costello, E. (1986). Primary care pediatrics and child psychopathology: A review of diagnostic, treatment, and referral practices. *Pediatrics*, 78, 1044–1051.

MacPhee, D. (1984). The pediatrician as a source of information about child development. *Journal of Pediatric Psychology*, 9, 87–101.

Needlman, R., Fried, L., Morley, D., Taylor, S., & Zuckerman, B. (1991). Clinic-based intervention to promote literacy. *American Journal of Diseases in Children*, 145, 881–884.

Olson, D., Torrance, N., & Hildyard, H. (1985). *Literacy, language, and learning*. New York: Cambridge University Press.

■ An Integrated Package of Primary Prevention Parent and Teacher Training Interventions Impacting Predictors for Substance Abuse

Ruth Kaminski, Beth Stormshak, Roland Good, Mark Shinn, Edward Feil

In the past decade, a considerable body of literature has provided information regarding the prevalence and patterns of delinquency and drug use as well as the environmental and intrapersonal correlates of substance abuse (e.g., National Institute on Drug Abuse, 1986; Hawkins, Lishner, & Catalano, 1985; Jessor, 1979; Jessor, Chase, & Donovan, 1980). These correlates include, among others, the inability of children to get along well with other children, poor impulse control, lack of a stable, protective caregiving environment, poor school bonding, and academic failure.

Despite the growing body of literature documenting the characteristics and correlates of substance abuse in adolescence, much less is known about effective preventative interventions

(Goplerud, McColgan, & Gardner, 1992). While past preventative efforts focused on drug education in adolescence (e.g., "just say no"), current preventative efforts are aimed at the predictive factors that are thought to underlie substance abuse. Several longitudinal studies suggest that predictor variables of subsequent substance abuse can be identified as early as the preschool years (Block, Block, & Keyes, 1988; Kellam, Brown, Rubin, & Ensminger, 1983; Shedler & Block, 1990). Recent intervention research provides preliminary indications that interventions that begin early and target predictor variables may be able to change behaviors and alter the developmental trajectories of children who are at-risk for substance abuse (e.g., Dodge, 1993; McMahon, 1994).

The goal of this project on Substance Abuse Prevention in Preschool: SupporT for At -Risk Children (Project STAR) is to develop and investigate the effectiveness of a comprehensive and integrated package of interventions in impacting variables during the preschool years that are predictors for substance abuse. This project will develop and test interventions designed to decrease risk factors by promoting and enhancing: (a) social competence, (b) self-regulation and control, (c) cognitive development, (d) caregiver involvement, and (e) school bonding. These areas are intervened through: (a) training of Head Start staff, and (b) parent discussion groups. The staff training process includes: (a) developing a training agreement with the agency, (b) didactic training, (c) field-based coaching, and (d) institutionalization (training staff to train others). The parent discussion groups utilize the videotape parent-training program developed by Webster-Stratton (1984), which has been implemented successfully with a range of both clinic-referred and normative families throughout 15 years of research. Following a developmental model of conduct problems, the program targets parenting skills hypothesized to be important in the maintenance of conduct problems in preschool and early childhood. The project stems from the MAPP project, which was recently selected as one of thirteen exemplary programs nationwide for the recent report of the Task Force on Head Start and Mental Health, Lessons from the Field: Head Start Mental Health Strategies to Meet Changing Needs (Yoshikawa & Knitzer, 1997).

Participants included 400 children enrolled in Head Start and their families in rural Oregon. The target population tends to be mobile, particularly in some of the rural Oregon communities that rely on migrant agricultural labor. The target counties are predominantly rural, ranging from 19 to 65 persons per square mile. In these counties, there are a few large cities; however, sites will not be recruited from those cities. These counties also include a large number of children in need, with 20-30% of children in the counties living in poverty. Forty sites were recruited, grouped into 20 pairs, matched as closely as possible on the SES status of the community, amount of staff training and experience, and degree of isolation of the rural community, and, then, randomly assigned to either experimental or control groups.

A combination of standardized, norm-referenced, observational and parent and teacher report data will be collected for all domains. Instruments were selected to be used as pre-post measures or to be used as dynamic measures over time. Pre-post measurements will provide information regarding the effect of Project STAR interventions on the outcome constructs in a summative fashion (i.e., at the end of each study year and the end of the 3-year study). Dynamic measures, on the other hand, will provide information regarding the developmental trajectory of each child's rate of progress over time in the study domains. Using hierarchical linear model procedures, the rate of progress of subjects in each group will be aggregated to establish and compare developmental trajectories across groups. The inclusion of dynamic measures of targeted-outcome variables is an important strength of the proposed research.

Dynamic measures administered repeatedly over time allow an examination of the effects of interventions on the growth curves or developmental trajectories of the subjects. For example, Hart and Risley (1995) examined the vocabulary growth curves of children from high-, middle- and low-SES families. They found clear and distinct differences in the developmental language trajectories of high- and low-SES children. By examining the trajectories directly, they not only

identified meaningful differences during the groups, they also were able to examine the implications of those trajectories. Children are impacted by these situations and present significant behavioral and educational challenges to the early intervention and Head Start programs that serve them. Evaluation data from the project and its significance for Head Start staff programming was presented. The success of this research also is enhanced by the strong links to rural Head Start programs through research and outreach efforts. The research addresses these issues and challenges faced by these programs, which are in need of effective intervention strategies.

References

Block, J., Block, J. H., & Keyes, S. (1988). Longitudinally foretelling drug usage in adolescence: Early childhood personality and environmental precursors. *Child Development, 59*, 336–355.

Dodge, K. A. (1993). The future of research on the treatment of conduct disorder. *Development and Psychopathy, 5*, 311–319.

Goplerud, E., McColgan, B. R., & Gardner, S. (1992). Introduction. In C. E. Marcus & J. D. Swisher (Eds.), *Working with youth in high-risk environments: Experiences in prevention* (OSAP Prevention Monograph No. 12, pp. 1–9). Rockville, MD: Office for Substance Abuse Prevention.

Hart, B., & Risley, T. R. (1995). *Meaningful differences in the everyday experience of young American children*. Baltimore: Paul H. Brooks.

Hawkins, J. D., Lishner, D. M., & Catalano, R. F. (1985). Childhood predictors and the prevention of adolescent substance abuse. In C. L. Jones & R. J. Battjes (Eds.), *Etiology of drug abuse: Implications for prevention* (Research Monograph No. 56, pp. 75–125). Rockville, MD: National Institute of Drug Abuse.

Jessor, R. (1979). Marijuana: A review of recent psychosocial research. In R. L. Dupont, A. Goldstein, & J. O'Donnell (Eds.), *Handbook on drug abuse* (pp.337-355). Washington. DC: Government Printing Office.

Kellam, S. G., Brown, C. H., Rubin, B. R., & Ensminger, M. E. (1983). Paths leading to teenage psychiatric symptoms and substance abuse: Developmental epidemiological studies in Woodlawn. In S. B. Guze, F. J. Earls, & J. E. Barrett (Eds.), *Childhood Psychopathology and Development* (pp.17–47). New York: Raven.

McMahon, R. J. (1994). Diagnosis, assessment, and treatment of externalizing problems in children: The role of longitudinal data. *Journal of Consulting and Clinical Psychology, 62*(5), 901–917.

National Institute on Drug Abuse. (1986). *Capsules: Overview of the 1985 household survey on drug abuse*. Rockville, MD: Author.

Shedler, J., & Block, J. (1990). Adolescent drug use and psychological health. *American Psychologist, 45*, 612–630.

Webster-Stratton (1984). Randomized trial of two parent-training programs for families with conduct disordered children. *Journal of Consulting and Clinical Psychology, 52*, 666–678.

Yoshikawa, H. & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs*. New York: National Center for Children in Poverty/American Orthopsychiatric Association, pp. 5–103.

■ Health Education and Training for Child Care Providers

Maureen A. Nalle

Increased utilization of out-of-home child care in the United States has been accompanied by growing evidence of the health and safety implications for children, providers, and the community. Lack of standards to ensure a healthy and safe environment, an increased rate of infectious disease, and the incidence of childhood injury are major areas of concern. Despite growing evidence of the association between provider training and practices and health and safety

outcomes in child care, caregivers rarely receive sufficient training to protect themselves or the children for whom they provide care. While health education is mandated in some states, there is great diversity and fragmentation in licensing requirements and no national standard to ensure health and safety in child care. Many child care staff have only a high school education; directors themselves may be poorly informed about health and safety issues in their centers. Because providers control the environment, health education is critical to protect the health and well-being of children and providers and to assure quality child care.

In recent years, child care and health professionals have collaborated to provide consensus in health education and training recommendations in child care settings. National health and safety standards established by the American Public Health Association, the American Academy of Pediatrics (1992), and the National Association for the Education of Young Children (1995) contain comprehensive health education guidelines for child care directors and providers. NAEYC accreditation criteria and revised Head Start Performance Standards also outline provider health education requirements. These standards and guidelines provide a necessary framework for the development, implementation, and evaluation of health promotion and health education strategies for child care providers.

Effective health education requires active involvement of providers in the identification of risk factors, health and safety concerns, and personal learning needs. Prior to training implementation, collaboration among staff, health professionals, and parents is often beneficial to establishing priorities, developing methods, and addressing barriers such as cost, time, and resources.

Trained and knowledgeable providers are an essential link between children and parents in the child care setting. Beyond the role of caregiver, there is growing recognition of the child care provider as health educator and advocate for the health and safety of children and families. In this capacity, the child care provider has the potential to increase parental awareness of health and safety issues, facilitate access to health services, and ensure positive child care outcomes.

Poster Forum: Comprehensive, Coordinated Service Delivery to Improve the Lives of Young Children and Their Families

CHAIR: Stephen J. Bagnato
DISCUSSANT: Richard Gonzales
PRESENTERS: Stephen J. Bagnato, Martha Isler, Susan Gestrich, Lawrence J. Johnson, Glenna Boyce, Mike Rice, Ann F. Minnes

■ The Early Childhood Initiative (ECI): Upgrading Early Education and Kindergarten Readiness in High-Risk Neighborhoods

Martha Isler, Stephen J. Bagnato

With an increased number of children living in poverty (Center for the Study of Social Poverty, 1991), welfare reform, and the increase of single-parent households, many communities are identifying ways to provide quality early childhood education to children from low-income families. Based on the premise that early childhood programs can "jump start" children to be successful, productive, responsible adults, the United Way of Allegheny County Early Childhood Initiative (ECI) has developed a plan to increase quality education for 7,000-8,000 children from low-income families. Following its mission of improving the readiness skills of children from low-income families for lifelong learning, ECI has developed a community-based collaborative effort to provide quality early childhood care for children.

The Early Childhood Initiative expects to develop quality early childhood programs for 7,600 young children in low-income neighborhoods in Pittsburgh and surrounding communities. Such quality programs will address the developmental needs of these young children, thus providing them with the necessary educational skills to be successful in elementary school and beyond.

With the overall purpose of ECI to help eligible children from low-income families become successful, productive adults by building the capacity to enroll them in high-quality early care and education services, ECI has identified specific goals for the project. These goals are listed below.

1. Elevate early childhood enrichment to a community-wide priority by creating a comprehensive public-private partnership from a 5-year start-up program to a long-term commitment.
2. Create an integrated system by assuring that new or expanded programs and services and those already in place complement, reinforce, or strengthen each other. Such services will link with existing services creating a collaborative comprehensive network that is responsive to community needs and accessible to families.
3. Expand the enrollment of children from low-income families in high-quality child care, Head Start programs, or preschool enrichment programs to include 7,500 new children over the course of 5 years.

The SPECS research design and evaluation strategies will enable ECI to monitor the impact of its comprehensive consultation methods on four categories of interrelated child, family, program, and community outcome variables. The SPECS Team will use assessment techniques that rely on the collection of authentic information in actual home, preschool, and community situations. SPECS evaluation strategies are unique in three ways: (a) They match the develop-

mentally appropriate quality guidelines of the National Association for the Education of Young Children (NAEYC) that emphasize convergent and multisource observations and ratings of child developmental and behavioral competencies in natural situations; (b) They do not rely on traditional "table-top testing" methods that remove the child, teachers, or parents from their natural situation or "developmental ecology;" and (c) They sample skills within the preschool's developmental curriculum that are predictive of future kindergarten success. SPECS assessment strategies are designed to chart changes in such areas as children's development (e.g., basic concepts, social skills, and self-control behaviors), parenting and family strengths, the quality and infusion of effective teaching and child care standards and practices in early childhood programs, and expansion of supportive neighborhood resource networks.

Child Outcomes Strand: The child strand emphasizes methods of collecting summative quantitative information on child status and progress. Based on the design that each child is his own control, information will be collected at three specific set time points during the evaluation year to document child change using Hierarchical Linear modeling (HLM). A combination of norm-based, curriculum-based, judgment-based, and ecological measures will be used by program staff to collect child outcome data.

Family and Community Outcome Strand: The central mission of this strand is to implement assessment measures that document changes that occur in ECI participant families in terms of perceived stress, family support, and the families use of community resources to nurture their child's development. The SPECS team plans to use reliable family survey tools and direct observational methods for collecting information on specific family variables. Through the use of survey forms and community assessment tools, this strand will also be responsible for documenting the improved capacity and capability of the community to network services for children and families within that community.

Program Outcome Strand: There are several missions that are central to the program outcome strand. First, the SPECS evaluation team must establish a trusting collaborative relationship with ECI program staff so that ECI and SPECS can work together to collect summative and formative child data. Second, the SPECS evaluation team will assist ECI in evaluating individual programs to determine the quality of each program, including each program's strengths and needs. Finally, the SPECS evaluation will be responsible for training program staff to complete child assessment data and to develop strategies for observing a child's developmental progress within the daily setting of the early childhood classroom.

■ HealthyCHILD: The Efficacy of Collaborative Integrated Developmental Health Care Consultation in Head Start Classrooms

Stephen J. Bagnato, Susan Gestrich

The HealthyCHILD program began as two multiyear model program development and research grants ($620,000) from the US Department of Education, Office of Special Education and Rehabilitative Services, and The Jewish Healthcare Foundation of Pittsburgh. The grants were awarded in 1994 and 1995 to Stephen J. Bagnato, a Children's Hospital of Pittsburgh/UCLID Center of the University of Pittsburgh faculty member. Project Child was incorporated into UCLID's training and research activities in 1995 as the central arm of its "community inclusion module." Since that time, HealthyCHILD has become the successor of Project CHILD and its community-based consultation and training activities are now supported by service contracts with the Pittsburgh Public School MOSAIC program, various Head Start programs, and other early childhood centers.

Project CHILD, the precursor to HealthyCHILD, was designed to plan, deliver, and research

the efficacy and efficiency of a transagency model for developmental health care services that addresses the needs of professionals, families, and young children (birth to 8 years) with chronic medical conditions, developmental disabilities, and early mental health concerns within inclusive early childhood classrooms. CHILD is an innovative partnership between Children's Hospital of Pittsburgh, Pittsburgh Public Schools, Western Psychiatric Institute and Clinic, primary care physicians, and other cooperating infant and early childhood programs. CHILD developmental health care services are delivered onsite in early childhood classrooms to teachers, team members, parents, and young children by a "core" transdisciplinary team consisting of a pediatric nurse practitioner, developmental psychologist, teacher, developmental pediatrician, and child psychiatrist. Developmental health care support services involving consultation, training, technical assistance, and some direct service emphasize the teacher's and parent's understanding and implementation of procedures that address the physical and mental health (emotional and behavioral) needs young children with developmental disabilities have that compound their developmental progress.

The following features distinguish the missions and methods of both Project CHILD and HealthyCHILD: (a) Pediatric medical and mental health consultation linked and coordinated with the child's Individualized Family Support Plan (IFSP) or Individualized Education Program (IEP); (b) Equal parent and family participation with professionals in making team decisions about the child's comprehensive developmental and health care needs; (c) An individualized Developmental Health Care Plan of medical and mental health goals and strategies that link with the IEP or IFSP; (d) Consultation and monitoring of medical treatments in the classroom and certification of teachers and support staff in medical procedures (e.g., asthma treatment, ventilator care, and behavioral interventions); (e) Improved communication and liaisons between the primary care physician or the hospital and the early childhood teachers and support staff; and (f) Ongoing staff in-service training to cope with the medical and mental health needs of young children.

Since 1994, Project CHILD and now HealthyCHILD have served over 100 children and families and trained 300 teachers and other interdisciplinary team members in individual and group training sessions. The ongoing yearly contracts ($75,000) with Head Start and Pittsburgh Public Schools have institutionalized the training, technical assistance, and consultation activities that UCLID faculty and trainees provide to these individual programs and classrooms.

■ Head Start in Ohio: A Collaborative Model for Program Research, Evaluation, and Design

Lawrence J. Johnson, Victoria W. Carr, Mary Marx, Dennis Sykes, Susan Rohrbaugh, Mary Lou Rush

This presentation addressed a range of studies conducted by the University of Cincinnati's Arlitt Child and Family Research Center in partnership with Ohio educational and child-serving agencies. Each study was developed as a collaborative research or program evaluation partnership with the overall goal to improve Head Start programming in the state of Ohio. The studies presented include: (a) a statewide evaluation of Head Start programming, (b) a collaborative effort to implement a developmental assessment instrument for Early Start programs, and (c) a collection of collaborative evaluation projects currently being conducted in Region Va and Vb to develop new models for evaluation of Head Start and Early Start programs in Ohio and other Region V states. The focus of this presentation was the design and implementation of collaborative methods for evaluation and assessment in Head Start programs.

A statewide evaluation of Head Start programming was conducted as a collaborative effort

between the Evaluation Services Center of the University of Cincinnati and the Division of Early Childhood Education of the Ohio Department of Education. Qualitative data analysis was used to extract pertinent findings from extensive interviews with Head Start program directors and parents. Additionally, program files were sampled at each site for demographic information on Head Start participants.

The Arlitt Center is currently engaged in an ongoing partnership with the Hamilton County Community Action Agency to develop an early childhood developmental assessment instrument for Early Start programs in southwest Ohio. Key elements of the assessment process include: (a) early identification of at-risk children, (b) development of referral linkages for needed services, and (c) tracking mechanisms to assure continued services for identified children as they progress through preschool and enter kindergarten.

The Evaluation Services Center of the University of Cincinnati is currently working with Head Start's Region Va and Vb Quality Network, covering the states of Ohio, Illinois, and Indiana. The Q-Net projects that have developed out of this partnership focus on two primary objectives: (a) to develop an evaluation plan tailored to each state's assets and needs as they relate to early childhood professional development and the extent to which they are coordinated across each state and (b) to implement regional evaluation approaches specific to Early Head Start programs that will gather and evaluate data related to the nature, struggle, and needs of Early Head Start programs in each state. The goal of each process is to develop internal feedback systems for program improvement that bring evaluators into the culture of the client and promote increased client participation in the evaluation process. Issues of distance and communication are being addressed through development of a Quality Network that uses electronic networking and communication to facilitate the exchange of program and child-tracking information between Head Start sites, evaluators, and state agencies. Unique accomplishments and challenges of these projects include the distance and communication structures to be developed and the merging of organizational cultures as a result of the internal feedback focus of evaluations.

■ Lessons Learned From a School-Based Collaborative Service System: An Evaluation of Utah's Families, Agencies, Communities Together (FACT) Initiative

Glenna C. Boyce, Diane Behl

Children at risk for school failure often have multiple needs that leave them especially vulnerable to fragmented services. The school-linked service system, defined as a partnership among service agencies that collaborate planning and governing, was created in recognition of the important role schools play in our communities. The state of Utah, through the State Departments of Human Services, Health, Education, and the Administrative Office of the Courts has developed such a collaborative effort in its Families, Agencies, Communities Together (FACT) initiative. The jointly funded local projects provide family-centered, culturally competent services to at-risk children and their families. At the local level, children and families are served by teams composed of professionals from the above departments and parent advocates based in an elementary school. Typically, children served have (or are at risk for) severe social, behavioral, and academic problems. Families have low levels of income and education. The FACT population has a higher percentage of single mothers, is more ethnically diverse than the state population, and the predominant minorities served are Hispanic and American Indian. Thus, the FACT population is similar to the Head Start population.

Adopting the school-linked service system approach is one way to offer collaborative or transdisciplinary services. However, research regarding its effectiveness is not commensurate

with its adoption as "best practice." In a literature review of 22 studies of school-linked programs, only 6 reported any outcome data. Clearly, a need existed for a comprehensive evaluation using a scientifically sound research design to determine the effectiveness of school-linked services. To answer this efficacy question, an outcome-based evaluation that asked the question, "Do FACT projects make a difference for children and their families in terms of child health, behavior, and academic development as well as family security and economic well-being?" was conducted.

Multiple quantitative (e.g., measures of parenting stress, family resources, child health, and academic and social development) and qualitative methods (focus groups and randomly selected case studies) were used to collect information from service providers, parents, and teachers to triangulate findings. A pre-post comparison group design involving children matched by the at-risk characteristics of the schools was used to evaluate school-based projects. Two school districts (one urban and one rural), each having both FACT and non-FACT schools, participated.

Findings confirmed that this was an at-risk sample in terms of demographic characteristics (ethnic minorities, limited education and income, single-parent families). Additionally, we found that reported parent stress was very high, often within clinical levels, and resources were minimally adequate. Services matched needs, to a great degree, except that teams had a difficult time finding medical and dental providers. Improvements were noted on some specific outcome measures (e.g., child social skills). Parent reports of FACT services were positive and in instances had life-changing ramifications for the family. Important to the issue of collaborative services, parents and teachers as well as service providers, had high praise of "teaming activities" and felt that the services they provided together were more family-centered and culturally competent than services provided before FACT.

■ Bridging the Gap Between University Researchers and Head Start Practitioners: The Role of a Private Foundation

Mike Rice, Ann F. Minnes

The presentation described both the historical and present involvement of a private foundation in Head Start programs for culturally and linguistically diverse preschoolers. The foundation's first involvement with Head Start was approximately 6 years ago when it sponsored and supported a Head Start program for African American preschoolers. The foundation saw the need to bridge the gap between theory and practice by linking university staff and Head Start practitioners. Moreover, the foundation recognized the need for evaluation. Thus, since its inception, longitudinal evaluation data has been collected every year. A review of the longitudinal evaluation data was provided. Also discussed were experiences gained from the 6-year partnership.

Given its previous involvement with the Head Start program for African Americans, the private foundation was approached by the local community to sponsor and support a Head Start center that would be comprised of Hispanic limited-English-proficient preschoolers. Staff from the foundation set out to establish a Head Start program that would effectively intervene with Hispanic limited-English-proficient preschoolers. The foundation, in conjunction with two other foundations, provided funds to build a Head Start center as well as a community center.

In order to establish the Head Start center with the best opportunity for success, the private foundation sought to bridge the gap between theory and practice by linking Head Start staff with university faculty who have conducted research and have expertise with Hispanic limited-English-proficient students. The foundation's involvement was the critical link to furnish Head Start staff with a theoretically-based culturally and linguistically appropriate program provided

by university researchers. Staff from the foundation have been present at all meetings with university researchers and Head Start staff. The private foundation also had school principals and other school officials attend the meetings with university faculty and Head Start staff in order for them to (a) provide input, (b) coordinate services between Head Start and feeder elementary schools, and (c) establish linkages for the collection of follow-up and longitudinal data once the preschoolers enter the elementary schools. Foundation staff brought all parties to the table to set appropriate goals for the Head Start center. Moreover, they provided information obtained from their experiences in establishing the African American center, especially with respect to funding the development of the curriculum and conducting program evaluation. The result of the private foundation's involvement has been to establish a collaborative model among constituents.

In addition to bridging the gap between Head Start staff and university faculty, the private foundation provided other types of support. Monetary support was given for staff training regarding literacy and to the development and implementation of the Spanish curriculum. In addition, the foundation provided each Head Start classroom with its own set of educational materials and books.

Developmental Psychologists and Head Start: A Warts-and-All Portrait of a Relationship

"Conversation Hour" with Sheldon White, Edward Zigler

Sheldon White: This symposium will address the relationship of developmental psychology to Head Start, and I hope that we will have a warts-and-all discussion of that relationship.

I am very interested in the history of developmental psychology, particularly its social history. Why have people in the 20th century suddenly started studying children? Why have parents who have been raising children for a million years suddenly started buying books about how to rear children? Why have teachers who have been teaching children since the beginning of human culture somehow needed to benefit from courses on educational psychology? Since I have been involved with Head Start over the years, I have been particularly interested in the relationship of developmental psychology to Head Start.

In addition to myself, Edward Zigler and a number of other developmental psychologists have been steadily involved with Head Start from the very beginning of the program. Recently, Deborah Phillips and I presented a paper in which we talked about the relationship of Head Start to developmental psychology, identifying four kinds of relationships: (a) representation, (b) demonstration, (c) idealization, and (d) evaluation.

By representation, I mean simply that developmental psychologists have been among those who have made public the condition of children and the circumstances of poor children's lives. They have been involved in the preparation of social indicators—data that are revealing of the condition of the poor and that have played a part in the creation of programs such as Head Start. In addition, analyses of the circumstances of the poor have played a part in determining what the programs have tried to provide for those poor children.

Developmental psychologists have been involved prominently in demonstration. Head Start began after a series of programs, including Susan Gray's program, Bereiter and Engelman's program, and David Weikart's program, had prepared the way by showing the possibilities and feasibilities of action for poor children. Those demonstrations played a part in the creation of Head Start.

The third function that developmental psychologists have brought to Head Start is what I call idealization. It is a theory of intervention; a notion of what might be done to benefit the lives of children and their families by a broad-gauged program such as Head Start. It is one thing to show that in Murfreesboro, Tennessee, somebody has done something positive for some poor children. It is another thing to say that if we expand the scale of the operation, something positive will happen for more children.

Finally, the last relationship is evaluation. There is a long story to be told about the role of developmental psychologists in evaluation. Since this is an aspect of Head Start with which I have been involved since the 1960s, I am going to resist the temptation to provide a long talk about the vicissitudes of evaluating Head Start and simply say that developmental psychologists have been very prominent among those who have used scientific studies to try to discuss what Head Start is accomplishing.

There have been positive as well as problematic outcomes from each of these functions. While developmental psychologists have represented poor children and described the circumstances of their lives, at times, developmental psychologists have come up with complicated, unrealistic theories about what the lives of the poor are like.

Zigler and Valentine (1979), discussing the role of social science professionals including developmental psychologists, near the beginning of the program, wrote that: "Unfortunately social science professionals reinforce these popular misconceptions by creating a stereotype of the American poor family on the basis of very meager research."

According to this stereotype, the poor child was deprived not only of the health and nutritional care that the family could not afford, but of proper maternal care and environmental stimulation as well. Poor mothers (fathers were assumed to be absent) were characterized as immature, harsh disciplinarians unable to love because of their own dependency. The environment was either understimulating (e.g., insufficient toys, interaction, and attention) or overstimulating (e.g., noise, fighting, or both). Verbal activity in the poor household was supposed to consist of body language, such as monosyllables, shouts, and grunts.

We had a summary of what much of the data seemed to suggest about poor families, but it was not based upon careful studies of what the clientele of programs such as Head Start needed. It was a stereotype of the poor. I think that some developmental psychologists have to accept the blame for some of the stereotyping that has occurred.

The results of the demonstration programs were very invigorating to read. Some were remarkably effective. However, in the 1960s when the demonstration programs were ongoing, developmental psychologists were enamored with cognitive development. Piagetian theory was very popular. There were many people in the universities who identified child development and cognitive development. The demonstration programs tended to exaggerate the issue of cognitive development and minimize the other issues involved in bringing relief to poor children and their families.

In the case of idealization, somehow the most widespread theory of intervention of Head Start at the very beginning was a theory of IQ modification. I have gone through the congressional testimony trying to determine who put IQ modification on the table. What I find in the congressional testimony is that Edward Zigler and Uri Bronfenbrenner resisted it, and a few people noticed it, such as Sargent Shriver and Jule Sugarman. However, the majority of people who talk about Head Start do not talk about IQ modification.

Somehow this giant theory came thundering down the road that Head Start is an experiment in IQ modification. Shortly afterwards, Arthur Jensen proclaimed that it was scientifically impossible. Now we have a third generation of conflict about this with the Bell curve. It is a theoretical Frankenstein, and the people who are guilty of it are to some extent the developmental psychologists—some of us at least.

Finally, in the case of evaluation, Head Start is alive today and growing, but it nearly did not make it past the Westinghouse evaluation. I was on the advisory committee for the Westinghouse evaluation of Head Start. There has been a long struggle to try to create studies that are on the one hand scientifically valid and on the other hand meaningful, in terms of giving us information and not throwing us off the cliff.

It is this history that I am interested in discussing today as well as trying to come to terms with what is a meaningful, useful relationship of a field like developmental psychology to a program such as Head Start. Additionally, what does Head Start contribute to developmental psychology?

Edward Zigler: First, the Westinghouse Report was an absolute disaster for Head Start. In fact, Head Start got a one, two punch in 1969. First was the Westinghouse Report, which said there was no lasting effect of Head Start. Next was the extensive 1969 Harvard Educational Review, a long monograph written by Jensen that once more looked at the nature/nurture issue that has been debated for at least 100 years and probably longer.

The opening sentence of the Jensen report was: "Compensatory education has been tried and it has failed." What that had to do with a standard behavior genetic analysis of intelligence I do not know, but there it was. In fact, the whole monograph contained approximately five pages about the genetic inferiority of African Americans. Had those five pages not been there, nobody would have paid any attention to that monograph. Yet the Westinghouse Report was even more deadly because the Office of Economic Opportunity, where Head Start was housed, commissioned it.

At that time, there was a research committee within Head Start that consisted of Uri Bronfenbrenner, Ed Gordon, who was the head of research within Head Start, and myself. We did everything we could to ensure the study was well done, because when we reviewed the research design, we knew from the outset that it was going to be sloppy. I also questioned the integrity of the data.

Westinghouse was a disaster. However, in the interim we had a new president. Head Start was President Johnson and Shriver's program. The new president, Nixon, hated the Office of Economic Opportunity and had no interest in the War on Poverty, which he essentially abolished.

Unfortunately, about 1970, I was the federal official responsible for Head Start and had to keep this program alive in the face of Jensen stating that compensatory education had failed. At that time, there was only one national compensatory education program—Head Start. Jensen was essentially saying that Head Start had already failed, even though we had just started in 1965. It takes 4 years just to get a program up and running. Granted, we started Head Start too big and too fast.

Sheldon White was an advisor to the Ohio Group, which was conducting the Westinghouse Report. When it came time for the advisors to sign off on the report, he saw the shortcomings and refused to sign off on it, essentially rejecting it. That took a lot of courage.

Interestingly, the research committee that I mentioned was not opposed to evaluation. However, we believed that evaluation should be done carefully and thoughtfully. This is where the psychological community essentially let us down. We met with researchers from the Educational Testing Service (ETS) and said that we needed a quick, good, solid, longitudinal evaluation at several sites about the impact of Head Start. The Office of Economic Opportunity funded the study. We did not get the report of that data for 20 years. Jeanne Brooks-Gunn, who was not even there at the beginning, finally reported it.

Sheldon White's history of the four factors is correct. In my own writing, I have emphasized two factors about the synergism between interventions like Head Start and psychology or child development. They are within his four. The first is theory. Where do these programs come from? Is there a formulation? What does it dictate in the way of implementation? What does the theory tell you to do?

The second important role is evaluation. One of the reasons these Head Start National Research conferences exist is the huge gap that has existed from the beginning between practitioners and researchers. Practitioners love their programs and know that they work. Their response to evaluators is to just come in and watch. They generally do not like researchers. We researchers do not talk to practitioners enough; that is why this meeting is so important.

Practitioners do not understand that there are two roles in research that are important: process evaluation and outcome evaluation. Both can improve programs, but certainly we should never conduct an outcome evaluation before a process evaluation. There should be an immediate feedback loop to practitioners that communicates the stronger and weaker aspects of their program. This stems from process evaluation.

I have had practitioners in my neighborhood come to ask me if what they are doing is effective. They want an evaluation. This is not typically the case, however. Most practitioners are so committed to their programs that they do not see the importance of evaluation. However, we have never convinced practitioners of the role that evaluation plays in Washington so that the flow of money continues to them. They often do not see the relationship between their program and the role that evaluation plays in Washington.

The Westinghouse Report was so devastating that it almost ended Head Start. The Comprehensive Child Development Program (CCDP) evaluation, which was discussed at this meeting, has also had a devastating effect. The CCDP was a 5-year early intervention for poor families that used a case management strategy. In my view, it was a weak program combined with a weak evaluation, and, of course, the outcome did not yield positive findings.

Doug Besharov at the American Enterprise Institute has testified to Congress that Head Start spends $10,000 a year per child and still has no findings. We have been beaten about the ears, and it finally reached its nadir when an article in Newsweek was followed by an op-ed piece in the Washington Post that said the same thing: The CCDP has failed, and, therefore, we should not be mounting these interventions. Parents should take care of their children and government should stop trying to mount interventions for children.

People like me have to go up to the Hill and testify about the question asked of Head Start for the last 33 years: Does it work? This is a perfectly legitimate question. Head Start's appropriation is $4 billion a year, and Congress has every right to know what it is buying. Yet, I can only report the evaluation findings we have and what I think they might mean. So it is very important that practitioners understand that when researchers give them additional tasks for which they cannot find time that these evaluations are critical in determining whether the program will continue or not. We must convince practitioners of that.

I would like to discuss theory. There is an intimate bond between theory and program development. Frankly, this worries me about Early Head Start. David Olds has a very successful home visitation program that was carefully developed from a sound theoretical basis. It was put into place slowly and carefully, with process evaluations completed long before random assignment evaluations.

The Administration on Children, Youth and Families (ACYF) has just mounted Early Head Start (EHS), and Congress wants us to increase funding from 5% to 10% of Head Start's budget. Ten percent of Head Start's budget is $400 million. I was one of the planners of Early Head Start, as was Sheldon White. What is the theory? The theory should lead you to the program. What is Early Head Start? Why is Congress so enthusiastic?

The theory is about brain development, which has received extensive coverage in the media. Research tells us of the importance of the first 3 years of life for brain development. It is beautiful science, but it does not reveal how to design a program. There is no well-articulated theory underlying Early Head Start other than that the first 3 years of life are very important. In many ways, I could resonate positively to that. Most of us know that if you want to impact the lives of poor children you ought not to wait until a child is 3 or 4 years old. You should begin prenatally.

We do have a lot of knowledge and information that tells us what a good program should look like. Zero to Three provides technical assistance to EHS programs and houses a great deal of the wisdom. First, there is no Early Head Start "program," but rather there are many models. The evaluation study is going to be done at 17 sites and will measure startup times just as CCDP did. Donald Campbell said it so well many years ago: you only evaluate a program when that program is proud. You do not measure startup times. We did not wait with CCDP, and we are not doing it with Early Head Start. We are making the same mistakes over again.

I have one final point to make about theory. Bad theory leads you to stupid ideas. I was on the Head Start planning committee, and our goals did not include any mention of IQ. Before I got to Head Start, I had spent my entire career studying children who were mentally retarded. I know how hard it is to change somebody's IQ. Furthermore, I have argued for years that a child's behavior is not an inexorable reading of his IQ. The child's motives, goals, and character also need to be factored in. The biggest correlation we found between IQ and school performance was about 0.7, which means IQ is only accounting for about half of what happens in school. We have tended to ignore the other half.

Probably the most popular book of the 1960s was Hunt's *Intelligence and Experience*. The second was Bloom's *Stability and Change in Human Characteristics*. Hunt's book was more influential. I spent the entire 1960s debating Hunt. We were very good friends, and he was a brilliant man; we just disagreed.

Scarr referred to his work of that period as naive environmentalism. Cognition was important in that period. Hunt had discovered Piaget, and cognition was the center of all things. He

believed that very small changes in the environment would produce huge changes in cognitive development. This is why everyone expected huge IQ changes from Head Start. The first Head Start program was 6 or 8 weeks long. Eisenberg conducted a good pre- and postdesign study of Head Start with a comparison group. It was accepted science at the time—not random assignment, but a quasiexperimental design.

Eisenberg found that Head Start had increased IQ by 12 points. That gave a big impetus to measure and change IQ, which led to about 10 years of work on my part. Everybody thought that when you give a child an IQ test, you get a clean readout of his brain and his neural system or intelligence. I disagree. I think that when you give a child an IQ test, you tap his formal intelligence in the Piagetian sense, but you also measure achievements, including what kind of life the child has had. That is where the cultural fairness issue comes in. If you ask a poor child what a gown is and he has never heard the word, there is nothing wrong with his intelligence. He has just never had an experience that gives him this particular achievement.

IQ tests measure formal cognition, achievement, and, most importantly, motivation. Motivation and these other aspects are very important, but they were not well studied at that time. So I started a body of research. I wrote a paper with Butterfield in 1968 entitled *Motivational Aspects of Changes in IQ Test Performance of Culturally Deprived Nursery School Children*. I demonstrated that when you get IQ changes, you are really providing the child with an experience that makes the testing situation and strange adults more comfortable. The paper's conclusion is that you are changing the child's motivational system, which can be changed fairly quickly.

There were a lot of other mistakes made. Riessman wrote a book entitled *The Culturally Deprived Child*, which is a misnomer. There is no group that does not have a culture. Riessman's work was disrespectful to certain people by implying that the only culture worth having was mainstream, White, middle-class culture. Unfortunately, Lady Bird Johnson picked it up and gave a speech in which she said that we have poor children in this country who by the time they get to school do not know their own names. This came right out of Riessman's book on cultural deprivation.

Think of a one-item IQ test. When does a child master his own name? If a child does not know his own name or cannot respond to it by the time he is 2, never mind a 5-year-old, you begin worrying,

This demonstrates the nonsense of the 1960s. Asking a child his name on the first day of school is inappropriate. If you are a poor child, the question is: What do you want to know for? Many minority communities encourage children not to talk any more than necessary.

I conducted a little study to determine whether children knew their own name. We just did something simple, such as if a child said, "I don't know my own name," we would respond, "Well, you probably want to know why I need to know your name. We're going to have juice and cookies later, and if I don't know your name, you're going to miss out on juice and cookies." Of course, if you do that, children know their name.

Let me illustrate how this research finding impacted programs. Once Mrs. Johnson detailed Riessman's finding about the children not knowing their name, the planning committee visited Head Start centers during that first summer. The children must have thought adults were nuts! Teachers would put a child in front of a mirror, then they would write the child's name in bold print above the mirror. They were teaching children their names. That was the link between theory and program. If Riessman's theory is that children do not know their own name, teach them their name because that is a good thing to know.

The IQ issue was destroying children and destroying our program. IQ is the most stable measure in psychology after about the age of 8. Even at age 4 it is fairly stable. Why anybody would ever change such a stable measure as a criterion of success of a program is incredulous.

However, Sargent Shriver wanted to go before Congress with his cost benefit analysis of Head Start. He wanted to determine how many IQ points we had added to children in this country, cost out what that was worth, and that would be his testimony. Fortunately, we were able to talk

him out of that. So I did everything I could to change the misconception that the goal of Head Start was IQ change, and eventually, we were successful.

Now we try to measure social competence in the evaluation of early intervention programs. Social competence is not a complicated construct. What kind of measures do you need to capture it? Health is a part of social competence. Cognition is another part. Experiences do indeed help. My best assessment is that about 50% of intelligence is determined by experience. Instead of Hunt's 100-point reaction range, both Cronbach and I independently came up with about a 25-point reaction range, which means that if you have a genotype for intelligence, the difference encountered between the worst environment versus the best environment is the reaction range.

Achievement is also important. Kindergarten teachers want children to know the difference between a square and a triangle, and they want children to be able to count to 10. These are achievements, and if you have had certain experiences, you can do all those things. However, most important are the motivational and emotional factors in the lives of children.

White: When Ed and I began in the 1960s, a lot of the use of research in Head Start was mediated by flying professors. I was a flying professor. You got up at the university in the morning, flew down to Washington, and then flew back in the evening.

Now we have a very different situation. This is the fourth national conference of people working on research on Head Start. There are about 800 people attending this conference, representing a widespread community of people working on Head Start research. I am pleased that the National Head Start Association has a research arm and is now organizing and mustering research.

Now, I would like to pose a question for people to think about. What steps can we take to organize more intelligent and more constructive interfaces between research and practitioners? I am interested in both the positives and the problems of avoiding some of the negatives.

Comment: While these national research conferences serve to initiate dialogue, I believe that researchers and practitioners involved with Head Start need to have more local level discussions to further the research agenda. We need to have more local partnerships and projects.

Zigler: There is a lot going on in Head Start that does not happen at this meeting and that is not national. For example, I have a Head Start research unit at Yale, as do many colleges and universities. All of this is local and can be and should be local. I meet constantly with all the Head Start directors in Connecticut.

Your remarks reminded me of a new mechanism, the Head Start Quality Research Centers, funded by ACYF. Four centers have been funded by ACYF: the Frank Porter Graham Child Development Center at the University of North Carolina-Chapel Hill, Georgia State University, the Education Development Center in Massachusetts, and High/Scope in Michigan. They are doing what you have suggested. They work very closely with the Head Start centers in their locality. Improving quality is their major charge as well as assessment.

There is also another mechanism called the Head Start University Partnership grants. These also speak to what you are talking about because they try to get university people to tie in with practitioners and work together to develop issues that both parties think are important. It is not just researchers dictating the terms of the relationship.

Question: Could you address the broader relationship of developmental psychology to other disciplines and social programs?

White: That is a fault of my presentation, because as a developmental psychologist I am interested in the relationship of developmental psychology with the world. I have been working side-

by-side with sociologists, political scientists, and anthropologists on questions of Head Start for the last 30 years. For Head Start, I think the question is what is a meaningful connection with the academic disciplines that have a bearing on what Head Start does?

Zigler: Your question is a good one. Many years ago, I wrote a paper about different levels of analysis. It is an interesting phenomenon. For example, when sociologists talk about schizophrenia zones of the city (an old finding that schizophrenics are found in certain areas of the city), they talk about drift hypothesis and other issues. If you talk to psychologists who do not understand the construct of zones of the city, they want it reduced to some other question. They start discussing where the boarding houses are located and conclude that it is isolation that produces schizophrenia. If you then talk to biologists or physiologists, they would ask, "what is isolation?" They would want to know what is happening at the cellular level

It turns out that when you operate at one level of analysis, the other levels have very little interest to you. They look wrong. That is not our question; that is somebody else's question. However, these are all absolutely legitimate levels of analysis. Sociology is not any less legitimate than psychology. Psychology is not any less legitimate than biology. They are doing different things. Finally, we are going to have to put all this together in some comprehensive, overarching theory, but there is plenty of room in Head Start for this.

Comment and Question: One thing that strikes me is that when Head Start was created in the 1960s, there were not as many other programs around. Now there are many early childhood programs of all kinds, in the nonprofit, private/public, and for-profit sectors. The economic social context of Head Start and the changing landscape of early childhood programs is something that has to be addressed, certainly with the 1996 welfare legislation that requires mothers of Head Start children to enter into the work force, which also is impacting children. What exactly can we do now as researchers to try to explore what the possibilities are for Head Start in the climate of 1998?

White: In my mind, there has been a need for years for some kind of diversified look at not only Head Start but various approaches to early education and their impacts on families and children. One of the big contributions that I think *Head Start Research and Evaluation: A Blueprint for the Future* made about 10 years ago to our thinking about research on Head Start was its identification of the fact that there is no one standard Head Start model. There is no one standard answer for whether a Head Start program is doing something. In fact, there is no one standard clientele. The stereotype back in the 1960s was that Head Start was a program for urban, poor, African American children who had every problem under the sun that one could imagine. We know now that is not true.

It is the role of researchers to begin to try to build a more complicated picture of what the different kinds of early education have to offer to children and their families to create a sense of the wider possibilities of intervention in the early years. Instead of asking what Head Start does or does not do in singular terms, we have to look at the variety of programs out there and begin to think about what the possibilities are for the instruments we have developed.

In my view, every single Head Start center is an experiment, on the part of local people, in which they have attempted to use the resources at hand to meet the needs of the clientele at hand. There has been a need for some years to harvest the findings of Head Start centers for the benefit of other Head Start people. We have generated a number of different kinds of approaches, which we need to somehow become aware of, reflect upon, and make part of our understanding of early education.

Zigler: This is an important question because it has important implications for Head Start and what it is going to be in the future. One thing that people should be aware of is that there are

currently 30 states that have mounted early intervention programs for poor children. Georgia has it for all children. Connecticut will have it for all children. California has it on the drawing board. New York and New Jersey are just getting started..

What does this mean for Head Start? We are finding in certain places that Head Start and these state programs are competing for the same children. Wade Horn, a former head of ACYF, suggested to the congressional committee that Head Start be sent to the states. Since the states already have programs, they can make a very strong case that if they received the federal money they could combine it with state money and have a more rational program. Doug Besharov has made the same case. At Yale, we are very close to completing a state-by-state analysis of what these programs look like, what their characteristics are, and how they compare to Head Start.

Frankly, I do not care who does early intervention, whether it is at the federal level or the state level. What I do care about is the quality of the program. I studied the research. I am convinced that the outcome of any intervention is going to be related to its quality and intensity. If Head Start were sent to the states, we would have a tremendous decrease in the quality of experience of the children, and as long as I feel that, I must continue to argue that it be kept at the federal level.

There is going to be another long-term development. The days of starting school at age 5 are numbered. The last Years of Promise Commission of the Carnegie Foundation recommended that we ought to be headed toward universal preschool education, and I agree.

After 33 years, we are serving half the eligible 4-year-olds in Head Start, and about 15% of the 3-year-olds. Eventually, we have to get some kind of system where every child receives a preschool education. We should universalize, use schools, and start children at age 3, as they do in France, Italy, Belgium, and Hungary. What does that mean for Head Start?

It is not going to be imminent, but when it happens, and it will happen within the next 20 or 25 years, then Head Start may take its stand totally in the first 3 years of life, starting prenatally, so you can really be doing something before the child goes to school at 3.

The last part of your question is about child care and the new welfare reform, which has changed the lives of so many people who need and use Head Start. This is very problematic for Head Start. I argued in the 1970s, when I was responsible for Head Start, and again in the 1990s, as a private citizen, that Head Start is not a child care program. We will get no credit on Capitol Hill for providing child care, even though some say that is what they want us to do. Head Start is an intervention directed at school readiness. That is where I am going to take my stand. If we cannot demonstrate that we are improving the school readiness of children, which will be the focus of the new Family and Child Experiences Survey (FACES) effort discussed at this meeting, we are going to be in very serious trouble on any grounds.

Now, after saying that, Head Start has a long and honorable tradition of trying to meet the needs of the families served. One of the great needs of the families that it serves today is child care.

I have been an advisor to the powers that be. If we had unlimited money, my position would be simple: We should make Head Start a full day. If a mother or father does not want a full day, the child can stay a half day.

However, we do not have the money to do this. People keep giving Head Start things to do, but they do not give us the money to do it. My advice to the Clinton administration was and continues to be to let us do our best to try to get local Head Start centers to find other money. We have a lot of money in the Child Care and Development Block Grant, and we should use that money for wrap-around services. We now have in this country many models that are doing exactly that.

There is a booklet from the Children's Defense Fund that has five different models. Head Start people at the local level are very entrepreneurial. They are doing wrap-around services well, and we are going to see more and more Head Start centers do this. When I advised the lawmakers in Connecticut on their bill, I suggested having preschool for the children but

making the day as long as the parents' work day.

Some day we will resolve the child care crisis in this country by using schools more than we do now. The schools are there, and they get money every year. I am not going to spend any more time trying to solve the child care crisis, which I have been working on now for 35 years. We will probably do better by trying to solve child care for everybody, not just for Head Start families, because then we will have a constituency for ideas.

I must say something somewhat negative to the Head Start community. Congress is very concerned about the lack of integration or coordination between Head Start centers and the state programs and the state powers. I hear from too many people as I travel around the country that the Head Start people get their money, they do their thing, and they do not cooperate enough with other people doing similar things. There is not enough cross-fertilization between Head Start people and the early childhood field, and a lot of this is Head Start's fault.

The Administration on Children, Youth and Families established the Head Start State Collaboration projects in every state, but they are not uniformly effective. It is a challenge to interface the various programs at the local level when Head Start is just one player, but we are going to have to do better at it.

Question: What does the research tell us about the quality of the education component?

Zigler: The education component has always had difficulties. Jimmy Hymes was very troubled by the quality of the educational component. In the original Zigler and Valentine book, I asked Eveline Omwake to write the chapter on early childhood education. When I asked her, she replied, "You don't want me to write the chapter." I asked, "Why not?" She said, "Well, the educational component is really not very good in Head Start." We depend a lot on that educational component if our business is school readiness. Evelyn did write the chapter.

The educational component has somewhat improved. Believe it or not, there were no performance standards for Head Start for its first 5 years. So we established the first performances standards, which have just been redone. Initially, Head Start centers had no curriculum. Quality has improved substantially since then. Now we insist on a curriculum, although a curriculum is no better than the people who are doing it.

I am troubled about the preparation of teachers. We invented the Child Development Associate (CDA), a certificate for those who demonstrate performance competencies in interacting with young children. Several years ago, ACYF stated that the goal of Head Start was to have at least one CDA running a classroom. Head Start serves high-risk children, who deserve the very best teachers that we can possibly provide. I am not satisfied with the goal of the CDA even though I have some pride of ownership. I want our children surrounded by the very best teachers. The secret of growth and development takes place at the intersection between the important adults in the child's life and the child.

Historically, there has been a tension in Head Start, which is still not resolved and talked about very much. Head Start people are suspicious of professionals. It goes back to our roots in the War on Poverty. From day one, many people thought of Head Start as a hiring program. We take great pride in reporting to Congress that one third of Head Start employees are former parents. There is something wonderful about taking a poor person and giving that person a job and training. However, who do we want to teach children? This will be a hotly debated issue. Neither Head Start nor I have ever resolved it. Why should we expect any qualified teacher to work in a program where the salary is about $17,000 on average a year? Teachers can make twice that much, if they move from Head Start to kindergarten.

Comment: I am from Arkansas, and I have been with the Head Start program since 1965. I want to speak to two things. First, you are concerned about practitioners' inservice training. We are part of two national research projects now, Early Head Start and Starting Early-Starting Smart.

We are also part of another research project about fathers' involvement in Head Start. I have attended all four of the research conferences. Being involved in the research aspects of Head Start has made a great deal of difference in our program.

I believe in professional development, and I would like to be a part of the discussions concerning certification. We have always made sure that college credit went to CDAs, that college credit went with inservice and preservice training. We believe in professionalism. We have done wrap-around services since 1987, and we operate some programs that are state-funded in addition to Head Start. Our programs are very comprehensive; we have good facilities paid for by sources outside of Head Start.

We have many Head Start programs in this country that do a lot of collaboration, and yet I have attended some meetings where you would have thought that Head Start did not do anything except in their own closed circuit. However, I do not see this happening that much any more. There are many good sound programs in our country that have accomplished things in spite of regulations. However, they have branched out and done it because of their own education or because of their boards and what they expect, or sometimes because it just is an innate right thing to do.

Zigler: I congratulate you because what you have described is terrific, and it confirms a couple of things that have been said. One is the entrepreneurial strength of local Head Start programs, which you have described to us. However, we still are not learning enough from each other. The fact of the matter is that Head Start looks different in different places. The notion about transfer of knowledge from one spot to another is important. Conferences like this help, but we have to have better mechanisms, some within ACYF, to help Head Start people learn from each other.

Enid Dradgeny: I would like to describe a small step that speaks to collaboration with the schools. The Department of Education and Cultural Affairs in South Dakota has a regulation that any school district that provides any kind of a prekindergarten activity or early childhood education must follow the Head Start Performance Standards. We work with all the public schools. It does make a difference and breaks down barriers.

Reference

Zigler, E., & Valentine, J. (1979). *Project Head Start. A legacy of the war on poverty.* New York: The Free Press.

Full Start: A Head Start-Community Child Care Collaboration

CHAIR: James Terry Bond
DISCUSSANT: Deborah Vandell
PRESENTERS: Dwayne Crompton, Shirley Stubbs-Gillette, James Terry Bond, Lisa G. Klein

This session presented findings from a 2-year outcome study of Full Start. Full Start is a partnership between Head Start and community child care that blends funding from Head Start, United Way, government, and private funders to provide comprehensive services to Head Start-eligible children attending community child care centers who may otherwise not be served. Given the current political and economic climate, there are increasing demands for child care and early care, and education services for children from families with low incomes.

Practitioners, policy makers, and funders have a variety of questions: How do you implement these types of collaborations? How can you maintain standards and high-quality care without significantly increasing costs? What happens to young children who participate in this type of programming? What makes this type of collaboration appealing to funders? The papers in this symposium addressed each of these issues. Program practioners outlined the "nuts and bolts" of implementing Full Start. Finally, interest and support for this type of collaboration from a funder's perspective were discussed.

Given the current political climate related to welfare reform, block grants, and the need for increased accountability, the KCMC Child Development Corporation worked with the Ewing Marion Kauffman Foundation which contracted the Families and Work Institute to conduct a 2-year outcome study of the Full Start Program. Key areas addressed in the study included (a) the overall quality of classroom environments, (b) the behavior of child care center staff, (c) the quality of teacher-child relationships, and (d) child outcomes in the classroom context.

Six key research questions were addressed in the study: (a) Are Full Start centers really better than community child care centers? (b) Can Full Start help an existing child care center quickly improve its quality? (c) Can Full Start bring community child care up to the level of quality expected of Head Start? (d) Does the quality of Full Start centers vary with the length of their participation in Full Start? (e) Do Full Start parents really want and use the comprehensive health and social services offered or are they an unnecessary expense? and (f) How satisfied are parents with the Full Start program?

The sample included representative groups of 146 3- and 4-year-olds from three centers in 1995 and 182 3- and 4-year-olds from four centers in 1996. A teacher sample included all center staff with direct caregiving responsibilities present during the time of the study. A total of 32 caregivers participated in the study.

A quasi-experimental design was employed. Effects were estimated by examining changes over time within centers and by comparing several program variations: (a) one program operating Full Start for 2 years at the beginning of the study (experimental center in 1995 and 1996); (b) one program operating Full Start for 1 year at the beginning of the study (experimental center in 1995 and 1996); (c) one program that began operating Full Start after the 1st year of the study (comparison center in 1995 and experimental center in 1996); and (d) one full-day, part-year traditional Head Start program (comparison center in 1996).

Eleven formal instruments were used for data collection in addition to extensive semistructured interviews with key informants and analysis of KCMC Child Development Corporation's internal MIS database. Data collection occurred over two 6-week time periods between May and July of 1995 and 1996. Data analysis included Pearson chi square on cross tabulations and one-way analyses of variance with post hoc comparisons.

Summary of Findings: Year 1 findings concluded that Full Start is a viable approach to improving the quality of existing child care programs in low-income communities. In addition, findings suggest that the partnership between Head Start and community child care did not result in sacrificing Head Start quality and performance standards. Overall, interim findings suggested that the Full Start program had a positive impact on teacher behavior, teacher-child attachment, child activity and behavior, and quality of the global classroom and center environments.

Findings at the end of year 2 confirmed those positive impacts. When the two existing Full Start centers were compared with a community center in 1995, there were strong indications that centers operating Full Start provided higher quality care than the care provided in the community center. The community center in this study served as a comparison in 1995 and began implementing Full Start in 1996. When this center was examined after 1 year of programming, findings strongly suggested that participation in Full Start after only 9 months had a significant impact on overall quality and child outcomes including: peer interaction, adult interaction with children, and object play. When the three Full Start centers were compared with one another in 1996, findings revealed that the third center was no longer distinguishable in quality from the other two. These findings positively answer questions about Full Start's ability to quickly improve the quality of existing community centers.

When average quality ratings from the three Full Start centers in the spring of 1996 were compared to ratings obtained at a local full-day, part-year Head Start center, no statistically significant differences were found. The outcomes for Full Start were at least as good as the outcomes for the Head Start comparison center. This suggests that Full Start programming can help existing community centers achieve the level of quality expected of Head Start.

Findings from this evaluation did not indicate that longer participation in Full Start is associated with higher quality. Factors contributing to this finding, such as staff turnover, should be explored in further studies.

Full Start is an innovative approach to addressing many of the needs of children from families with low incomes. Results from the study strongly suggest that short-term outcomes for children, staff, and overall quality improve as a result of Full Start programming. Given the small sample size and short-term nature of the present study, findings should be viewed as provocative rather than definitive. Follow-up studies are recommended to more fully understand program effectiveness and potential for broad-scale replication. A second evaluation is currently underway.

Changes in College and University Training Models for Students

CHAIR: John Hagen
PRESENTERS: Frances Degen Horowitz, Gertrud Lenzer, Deborah Coates, Celia Fisher

John Hagen: I am very pleased to serve as chair of this session, which is on changes in training models for students. We have conceptualized this quite broadly. Our models might be in colleges and universities or perhaps even in other settings. We are also talking about training from the undergraduate to the graduate to the postdoctoral level, perhaps even at the professional level.

One of the areas in which there always seems to be a lag is changing our training models. Research and practice move forward, but training is slower to move. There are various reasons for that. I heard a speaker some years ago say that it was easier to rearrange a cemetery than to change the departments in a university. There may be a grain of truth in that. However, I know that the presenters on the panel and some of the people in the audience as well have been involved in coming up with new and modified approaches to training, particularly the issue of training for the utilization of the knowledge that has been generated.

In the years that I have been in the field of developmental psychology and child development, we have had a tremendous change and increase in our knowledge base. Several speakers, in fact, have addressed this issue over the last few days. Jack Shonkoff made the interesting statement that we now probably have about 30% of the knowledge we need, but we are not using that 30% nearly as much as we could or should be. Those of us in academia are always much more comfortable in pointing out that more research is needed and that we cannot make a definitive recommendation as yet, because we do not quite have all the answers. Yet, again, many other people at this conference have pointed out that policy makers and practitioners have to make decisions that affect the lives of our constituencies, children, and families, whether or not all the science is there that we think should be there.

Now, I would like to introduce our presenters. Frances Degen Horowitz was at the University of Kansas and was one of the major influences in developing the program there into one of the preeminent interdisciplinary programs in the country. She now serves as president of the Graduate Center at the City University of New York (CUNY) and is president of the Society for Research in Child Development (SRCD).

Gertrud Lenzer is a professor of sociology at Brooklyn College and the CUNY Graduate Center and the director of the CUNY Children's Studies Center. She was the founding chair of the Sociology of Children's section of the American Sociological Association and was awarded the 1997 Lewis Hine award for service to children and youth by the National Child Labor Committee (NCLC).

Deborah Coates is a professor of psychology at the CUNY Graduate Center. She also ran a community-based maternal and child health intervention program for a number of years while on leave from academia.

Celia Fisher is director of the graduate program in Developmental Psychology at Fordham University and chair of the National Task Force on Applied Development Science. She is also co-editing a new journal entitled Applied Developmental Science.

Frances Degen Horowitz: I had the pleasure of listening to part of a session this morning in which people who have been involved in Head Start for many, many years reminded us how far we have come with respect to Head Start. When Head Start began, I was at the University of Kansas. No public entity would sponsor Head Start, because they would not be involved with the federal government. So the university ran the very first Head Start program. The department

of which I was chair was responsible for it. Then we passed it on to a volunteer community group until ultimately attitudes changed, even in Lawrence, Kansas, with respect to running a federally funded program.

I remember after we passed Head Start on to the volunteer group, and I went to visit the program. I walked into the room, and it was in total chaos. We made some suggestions about how the program might be organized and how the children could be handled. However, their response was, "Well, that's very nice, thank you, but we wouldn't feel comfortable making those changes." I do not think that there is any Head Start in the country where one could walk in today and get that kind of response because Head Start has been considerably professionalized. Having said that, however, the training that is provided and the preparation for people who work in Head Start and with young children have not come a long way.

The issue of training people to work with young children is an extremely critical one, not only just for Head Start, but nationally. Recently, there has been a horrendous case in the child welfare system where a child was terribly neglected. The caseworker that had visited just a few weeks earlier had only noted that the child, who was literally almost being starved, was very thin. She wrote that note, walked away, and took no further action. Of course, there has been a tremendous outcry. The question I ask, however, is what kind of training did that caseworker have? Did she know what a 2-year-old should look like? Did she know whether this is a variation in normality or is actually something that is so far off the scale of normality that it is something to be concerned about?

I want to make five points about what I think is essential in terms of training anyone to work with young children. First, training is needed in basic normal development, which has been a theme of mine throughout my professional career. We need to try to understand what we know, which is a considerable amount, about normal development of children, age-wise, but also about the variability within ages.

What is normal variability? What do you need to know so that if you walked into a home and saw a 2-year-old, you would not say, "Well, the child is thin," and go away, but instead would know by looking at the child that something might be very wrong that at least required further investigation. Professionals working with children need to understand the enormous individual differences in variability within normal development. When I taught introductory child development, I would say the normal range for the onset of walking is from 6 to 18 months. That is a huge normal range. However, you could have a normal child walking at 6 months as well as a child of 15 months who is not walking and who is also perfectly normal. Trained professionals need to understand the range of variability in the normal development of children.

Kathryn Barnard and I were cohorts with T. Berry Brazelton in developing the Neonatal Behavioral Assessment scale. In training people to use that newborn assessment, we set the standard that people should have experience with up to 50 normally developing babies to get an understanding of the normal range of development of newborns. Once you pass the newborn period, extensive experience is needed to train people to work with children to give them a sense of the whole range of normal development.

The second essential element of a training program is to have people with a good command of behavior management techniques and who really understand how to employ those techniques in a positive way. Early childhood professionals need to know what is age and developmentally appropriate and be able to call upon those techniques with ease in a seamless fashion, so that groups of children are not arranged in chaotic fashion in the classroom or in any type of group setting.

Behavioral management techniques have gone through ups and down in terms of people thinking of them as controlling children. I remember at Kansas, I had many colleagues who were behavior analysts. I remember a preschool organized along behavioral principles in which a teacher could look at a child and see some behavioral problems and then sit down with the staff to discuss techniques to use. Someone thought this was terrible because all teachers had to

do was love a child. I think we need to love children, but I think we also need to know how to employ positive behavioral control and management techniques, so that the settings in which children play and learn are ones in which real learning can take place.

The third point that I would like to make is that professionals in Head Start or any child-oriented program need to have a healthy respect for what I call the potentially swamping social and economic variables that impact a child's life. A child is part of a social and cultural system outside of Head Start or any learning situation. Therefore, we need to consider what is happening to the family in terms of family stability, job stability, money availability, and the neighborhood context, as they all have an impact on how a child is going to do. To know the success or failure of Head Start only by what happens in the Head Start classroom without understanding the larger context in which every child lives is very unrealistic. One of the things that Head Start has tried to do, perhaps more than any other program, is to take into account and try to work with community agencies on behalf of children.

The national welfare-to-work initiative, although some people think it is a panacea, will not in and of itself produce in chaotic families the kind of stability and economic security that we know is most helpful to children. Thus, it is critical to train people to have a healthy respect for these other variables that impact children's lives and ultimately to make connections with other agencies that may be involved in children's lives, so that the Head Start experience can be most beneficial to the child.

Training people to work with children in this dimension is not easy. How do you give them that experience? There is only so much book learning one can do. Ultimately people have to get out in the field. All of us have seen very experienced wonderful teachers who, beyond their training, have accumulated experiences that have given them this kind of understanding and perspective. Sometimes I see wisdom about children's lives. It is hard to give this to young professionals in the context of a time-limited training program.

The fourth aspect that I would like to cite is the need to have a clear vision of the curriculum so students understand the agenda. Early childhood professionals should know what children need to learn in terms of school readiness and working together in groups. The notion of teaching to the test has been, from my point of view, a very maligned notion. Middle-class and affluent parents teach to the test all the time. It is not that they sit their children down with a pencil and paper, but they have in their mind what it is that the children are going to have to be able to do, what kinds of proficiencies, capabilities, and knowledge they are going to need to negotiate the world. That is what I mean by teaching to the test. Professionals need to know how to structure the curriculum in such a way that it teaches to the test of what children will have to be capable of.

Finally, the fifth point is that the training must be informed by the massive advances in our understanding of normal child development and the development of children with special needs. It is beyond just understanding normality; it is understanding cognitive, affective, and physical development. The four volumes of the most recently published handbook in child psychology is an attempt to capture the enormous knowledge base we now have. Even though it is only 30% of what we know, that 30% is very significant.

Giving people that knowledge base, both in terms of book learning as well as in terms of observation and working with children, is an essential part of creating a competent professional—someone who can go into a situation and know the nature of children and have an understanding of all the basic developmental aspects for which we are creating situations so that children can grow and develop as well as possible.

These are the five points essential to a professional training program: (a) understanding normal development; (b) having a good command of behavior management techniques; (c) having a healthy respect for potentially swamping social and economic variables; (d) understanding what the curriculum is or should be and arranging learning opportunities so that, in effect, one is teaching to the test; and (e) being informed on advances in basic child development.

Gertrud Lenzer: The topic of my presentation is the new pedagogy of children and students and the role of higher education in disseminating the knowledge from research, practice, and policy. The theme of Head Start's Fourth National Research Conference is directed to creating an agenda for researchers, practitioners, and policy makers with regard to children and families in an era of rapid change. More specifically, this symposium is charged with these changes in the university models for students. How can changes in college and university models for students contribute toward establishing a set agenda for research, practitioners, and policy makers when it comes to treating families and improving their well-being? I will present our undertaking of creating children's studies as a new interdisciplinary field of study in pedagogy at the City University of New York.

In the hope and anticipation that it will provide a model for other academic institutions, I will take the liberty of presenting a brief outline as well as certain aspects of assumptions that are foundational to the proceedings of this conference. My contention is that there are damaging deficiencies and a number of widely held and long-cherished assumptions among the community of researchers and scholars, not only in the field of child development, but in the social sciences in general.

The preconceptions I would like to challenge have to do with certain unexamined premises, which hold essentially that what is necessary for the betterment of society is to convey, translate, and put into action some of the vast knowledge held by the scientific scholarly community. A related corollary assumes that we can get policy makers to listen to and accept the findings arrived at by the community of researchers and practitioners for the purposes of promoting and enacting enlightened policies, or in the terminology of our conference, becoming partners in a shared agenda. This belief further holds that everything then would turn out better for our society and nation. To provide historical perspective for my criticism, I would like to go back only as far as the 1960s and the optimistic ventures of the behavioral and social science community reports, also known as the BASS reports, or the "Knowledge Into Action" campaign spearheaded by the National Science Foundation at the time.

Some of the shortcomings of these and many subsequent endeavors on the part of the scientific community are due to the fact that they focused largely on the exchange of information between three constituencies: researchers, practitioners, and policy makers. On this vulnerable line of reasoning, politicians and policy makers are and have been envisioned in much of that relevant literature as the recipients of insights and knowledge achieved by the research and scholarly community. As such, each day they are expected to translate research into enlightened policies, laws, and social programs.

To put it simply, however, what has been left out is the larger public as a constituency and as a fourth partner to any such envisioned shared agenda. Politicians and policy makers are indeed dependent—though less upon the scholarly community than upon their array of larger publics; that is, they are dependent upon their constituencies. Without them and their consensus registered as citizens and voters, the enlightened lawmaker, politician, and policy maker cannot be an effective partner of scholars, scientists, professional experts, and practitioners. In short, social science research and policy will be ineffective without directing substantial attention to the wider dissemination of scholarly knowledge. In so doing, it will act to create a public familiar with the insights gained from scholarly research and practice.

The object of this conference might perhaps be amended to "Creating a shared agenda between researchers, practitioners, policy makers, and the public." It is my opinion that it is this larger public—the community of citizens and their enlightenment—that should be added. We might even revise our conception and put the public first. With particular regard to the major advances in infant, child, and youth research that have been made throughout the past decades, one central challenge before us is to determine how to translate the privileged and expert knowledge of the research community into public knowledge. Without the accomplishment of this next important step in the education of the public, there is little hope that policy makers by

themselves would be able to join forces with scholars to initiate and effectively implement policies and programs based upon scientific knowledge.

An added complication faces us, particularly when it comes to children and youth. Every citizen, by and large, shares in traditional conceptions about children's needs and realities, no matter how sharply these beliefs may differ from the privileged and scholarly insights achieved by child experts. The time clearly has come when one major task before us has to do with how to convey to the public at large the insights garnered in the fields of child psychology, child development, and other disciplines that attend to the realities of children and youth.

For our purposes, we might wish to borrow a term and strategy that has been widely used in recent years by the international community and by international development theorists and agencies: capacity building. This concept refers to strategies that aim at forms of knowledge transfers and development of competencies on the grassroots levels to empower people to participate knowledgeably and meaningfully in the management of their own affairs. Put differently, the idea of capacity building is to strengthen civil society to participate in and assist the endeavors of government for improving the conditions of society generally.

It was precisely this task of creating a public educated in the affairs of children that led to the creation of Children's Studies in our program. In fact, we were guided by the idea of trying to disseminate knowledge about children from the various fields of research and study ranging from the arts, humanities, social sciences, medical science, and legal studies to students in the course of their liberal arts education at the undergraduate level.

From its inception, the purposes of the program were fivefold:

1. To disseminate knowledge about children from the research and scholarly disciplines to students as part of their general liberal arts education;
2. To provide students with knowledge about children from these disciplines as a foundation in their future careers and occupations;
3. To encourage students to explore the possibilities of pursuing children-related professions in law, medicine, the arts and media, education, social services, and so forth;
4. To provide them with knowledge that will help them in their future role as parents; and
5. To help establish an infrastructure of knowledge based upon research and scholarship about the realities, competencies, and needs of children in society as a whole, knowledge without which it is impossible for policy makers to promote effectively, enact, and implement laws and programs on behalf of children, their families, and society.

In other words, our emphasis was not on providing specialized training with regard to children and youth, but providing the fullness of all the education that we have available, including children's imagination, competencies, and social needs, to our students and providing them with the best knowledge that departments and scholars from these different disciplines with their specialties can offer them. Students do not necessarily have to go to graduate school and become psychologists. In whatever careers they may choose, the affairs of children may intersect with their professions in many ways. They would then have a background and knowledge that they acquired while in college.

If we were able to disseminate the knowledge at a much earlier stage, namely at the undergraduate level and in the context of learning and development, we would catch our citizenry at a much earlier age.

This task of creating a program of disseminating knowledge from the child expert community to the public at large, however, had to take into account certain realities of the disciplines themselves. From the end of the 19th to the end of the 20th century, intermittent phases have occurred in waves during which children and youth have been the objects of intense focus. Throughout this century, indeed every decade, White House conferences as well as Presidential commissions on children and youth have addressed the needs of children and youth and issued policy-related recommendations. This has meant that at repeated intervals, public attention focused on the needs of children and our national commitment to them and their families.

Concurrently, each wave of national concern about children and youth led to an ever-growing accumulation of child research and training of practitioners, developments that have in turn promoted the establishment and expansion of child experts. Historically, our knowledge base about infants and children has grown tremendously, along with the class of child experts in research and practice.

However, by the same token, the disparities between experts and public knowledge have widened. The example of the recent debates about child care policies and programs provides an important case in point. Traditionally, we associate the field of psychology, branches of social work, education, and pediatrics in their concerns for children and youth. Their history covers the better part of child-related research and its application and practice. During the last 2 decades, however, in addition to such highly professionalized academic fields as psychology and psychiatry, an increasing number of disciplines in the arts and sciences have also begun to manifest an interest in children and youth. In the humanities, these growing subfields include the history of childhood, children's literature, and the philosophy of children. Among the social sciences, there are newly emerging areas of the sociology of children in the U.S. and the sociology of childhood in Europe. Other disciplines such as anthropology, political science, and economics also produce, in rapidly increasing numbers, studies on child-related topics without, however, having established antecedently or concurrently a primary focus on children as a special branch of scholarly discourse and analysis within their special intellectual disciplines and organizations.

The recent sharpening focus on children and youth in the humanities, social sciences, and international law represents a welcome development. When we first established the Sociology of Children as a new section within the American Sociological Association in 1991, it became quickly evident that the intellectual division of labor in children-related scholarship across the disciplines was simply adding new subspecialties of and within the disciplines themselves and that these studies were disconnected from one another. We felt that it was incumbent upon us to develop a holistic conceptualization of children as individuals and as a class, in order to overcome the disciplinary fragmentation of children into an incoherent manifold of specialized perspectives and to develop a commensurate and genuinely comprehensive perspective on and analysis of children.

With such realization also came the recognition that the disparate disciplinary undertakings in question—the findings, theories, and codes of assumption—needed to be complemented by a reconstruction or synthesis at another level of integration, for children are not fully characterized by psychological developmental processes nor by any single perspective. In our view, children also exist on their own as individuals, as a class, and as a generation.

Hence, we cannot arrive at a comprehensive understanding of children by simply accumulating, aggregating, or adding up segmented findings from a far-flung variety of inquiries into disciplines. In response to the fragmentation in child research, Children's Studies was conceived of as a genuinely interdisciplinary, multidisciplinary new field of study. Children's Studies was an attempt to bring to bear knowledge from the different sectors of the arts and sciences on the conception of children as a class and to integrate this knowledge at an appropriate level of understanding and articulation. Children's Studies does not aim to achieve simply a sum of findings from diverse perspectives. By bringing carefully chosen knowledge of children from different studies to bear upon the class or category of children in the education of students, we hope that a more holistic understanding should emerge, which in the end will represent more than the sums of its parts.

At the City University of New York, courses include children's literature, the history of childhood, child development, sociology of children, children in education, child health, the African American child, the Puerto Rican child, and speech in children. Other courses are in preparation for the near future, such as a course on the rights of children. We also envision courses on children and the mass media, new technologies and the Internet, children and the environment, and children of the world, emphasizing cross-cultural and global perspectives in children.

The interdisciplinary capstone course, "Perspectives on Children's Studies," was developed by a faculty working group in weekly seminars during 1996 and 1997. When it was offered for the first time on an experimental basis in the spring 1997, the course was taught by six faculty members from the departments of History, English Literature, Film, Psychology, Sociology, and Public Health, and two guest lecturers from the children's rights community. The unified, yet multidisciplinary perspective is reflected in the five major units of the course itself:

> Unit One: The Past and the Self; Childhood in Pre-Modern Society; and The Emergence of Modern Childhood (with readings from autobiographies by St. Augustine, Erasmus, St. Theresa, J. J. Rousseau, J. S. Mill, and Frederick Douglass).
>
> Unit Two: The Child Imagining and Imagined; The Literary Heritage (readings from Blake, Wordsworth, Dickens); Children's Literature: The Classic Themes; Literature and Art by Children; The Picture Books: The Marriage of Text and Image; and Images and Words: Children and Film.
>
> Unit Three: The Developing Child; History and Theories of Child Development; and Points of Contacts With Other Units.
>
> Unit Four: Children and Society; Introduction to Social Perspectives on Children and Youth; Children and Social Problems, both in the U.S. and on a Global Scale; and Issues in Child Health.
>
> Unit Five: The Human Rights of Children: The International Agenda.

In this sense, the arts and sciences, from the visual and performing arts, music, film, and literature, from philosophy to history, and from the many disciplines in the social sciences, medical science, and legal studies, are brought all together and in an individual focus on children can be enlisted to bring about a new understanding of a new series of conceptualizations of children. From this perspective, the emerging rights of children, for example, are not conceived of as a separate formal inquiry that confronts other studies dealing with children and youth. On the contrary, the human rights of children are regarded as an intrinsic component of the disciplines concerned with children, since specific legal concerns pertain to the different specific aspects of the entirety of a child or the class of children.

By way of conclusion, let me say that the overarching goal, intellectual ideal, and proposed methodology of the Children's Studies program as well as of our newly established Children's Studies Center, is to bring about a more adequate, knowledge-based representation of children and youth in society by means of a new pedagogy and research methodology.

It is in this manner that the Children's Studies program and the disciplines can contribute to the well-being of children by promoting a knowledge-based and thorough understanding among the educated public and in society at large of children's capacities, capabilities, needs, and desires, as well as of their civil, political, social, economic, and cultural human rights. By concentrating our efforts on creating an infrastructure of enlightened knowledge among students, we hope to enlist the public as a fourth partner in our endeavors. We envision a future in which the multidisciplinary field of Children's Studies will play a significant role in promoting an enhanced understanding of children not only by reaching across disciplines, but also by exposing students to knowledge that will enhance their understandings and competencies in relation to children in their future roles as human beings and professionals in all walks of life and as citizens and parents.

The time has passed when the specialized knowledge we derive from research, scholarship, and practice is only available to the experts and practitioners. The time has also passed when

individual citizens are left to depend upon unquestioned or unexamined conceptions about child development, child rearing, and indeed, the very experiences of children. It is time that the privileged knowledge of the expert is shared with all the so-called nonexperts. We need to effect a major change in public awareness in the sense that children are viewed as human subjects, not merely as objects of social policies and social action.

We often hear about the object of social action. Einstein once made a remark about the obligations of the natural sciences: "A society in which a privileged class of scientists monopolizes knowledge about nature without attempting to make this very knowledge also accessible to all citizens is prone to dangers of authoritarian rule." In the interests of children and their families and an enlightened and empowered citizenry, we have created and advocate for the unified and cross-disciplinary approach to children's studies. Both the child expert and practitioner will find, in the long run, that the creation of this new pedagogy of children's studies, which pays attention to the competencies and realities of the whole child on behalf of all children, will provide a knowledgeable public able to participate in the social conversations and be partners in a shared agenda on behalf of children and youth. We hope that, towards this end, Children's Studies will provide a model for other institutions of higher education.

Deborah Coates: The purpose of this conference is to create a forum for considering the shared agenda among researchers, practitioners, and policy makers. My perspective is that of a trainer of students at all levels of university training, both undergraduate and graduate training, as well as postdoctoral training. I have also taken leave from the university to be in community settings.

I am going to talk about what I think we need to teach students in order to effectively prepare them to crosswalk these orientations. Of course, this involves asking the question, "What are the skills that students need to be acquiring at different levels—at each developmental stage—in their training?"

I also would like to describe some of the elements and activities of a training program that would address these objectives. Although I am not going to provide a very thorough description or in-depth analysis, I hope to generate some discussion and thoughts that will help us push this agenda forward. Now, in thinking about this, it is important to make explicit our purpose of integrating research, advocacy, and service.

Some people might argue that there is no reason to do that. We do not seem to explicitly deal with this or what our assumptions are about integrating this. However, my assumption is that it is possible in integrating these three perspectives to create solutions to enduring social problems that have plagued us and to change the quality of life for citizens, particularly the most disadvantaged among us. If this is true, it suggests that there are particular ways that traditional training for research careers ought to be changed.

Jack Shonkoff stressed some of the important contributions made by research, service, and advocacy that provide a very useful perspective for us in terms of knowing what we should emphasize in training in these areas. First, he suggested that research has three strengths to contribute. The first is conceptual model building, which is extraordinarily important. Ed Zigler has pointed out the important integration between theory and program development and how intimate that integration needs to be.

For example, we have a lot of research and theory on brain development that is currently driving Early Head Start programs. The idea of Head Start was clearly linked to theories on sensory deprivation, environment deprivation, and, of course, the misnomer of cultural deprivation, which was a misguided notion. Thus, this connection between conceptual model building and theory is a very important contribution that research has to make. Shonkoff also mentioned hypothesis testing and methodological rigor, or, I would suggest, quality control and process evaluation. The strength from this seems to come from our ability to measure behavior and to understand strategies for changing behavior.

The contributions of service are empirical knowledge, clinical judgment, and pragmatic

decision making based on very limited data. In the advocacy or social policy area, the primary contribution is the ability to take a multiple set of views and address a problem, science, of course, being only one view. The second is negotiating and compromise among competing interests. This provides a very useful framework in the area of university training that suggests what we ought to teach students to value in their own and others' perspectives. It suggests what we may want to emphasize for students who want to learn how to integrate these three perspectives in some way into their careers. Now, what is it that we want to teach?

I am going to make five points about skill development. First, I think we need to teach students how to think differently. We need to stress thinking skills other than analytic skills. I like to use Sternberg's model of intelligence to suggest that there are two other major thinking strategies that we need to stress. The first is creative skills and the second is practical skills. Some of the objectives in university training methods that I am going to suggest are much more heavily oriented toward creative thinking and practical thinking than they are necessarily toward analytic thinking.

We are all familiar with analytic thinking. Let me describe what I mean by practical and creative thinking. Practical thinking is the ability to contexturalize and solve problems that occur in one's own life and in situations in which one exists. Creative thinking is the process by which one synthesizes existing information and then transforms this particular synthesis into a new approach or some new strategies that can be applied to a problem.

The second area of skill development we need to consider is taking a much more developmental perspective in our training. If we want students to be able to do this integration, we need to consider what it would have to look like at the different levels of training: the B.A., Master's, and Ph.D. Early in a student's career, perhaps at the B.A. level when they are most likely to exhibit some kind of plasticity, we should expose them to a variety of disciplinary perspectives. By doing so, we would get away from the model of majoring in a certain field or promoting students early in their sophomore year into research careers and start exposing them to a variety of skills that they would develop in research, service, and advocacy at the beginning stages. As students enter midcareer training, such as at the Master's and Ph.D. levels, it might make more sense to then hold fast to particular disciplinary perspectives because there are certain kinds of skills and content areas that they need to know very well in order to be able to do integration later.

At the postdoctoral level, it would be important to increase the cross-disciplinary training again to get students to open up and be able to integrate these different perspectives more broadly and readily.

We also need to encourage research-trained students to use creative thinking in developing new approaches. They should not be wedded to particular methodological approaches, but rather should consider important questions for which traditional or quasi-experimental research approaches or even qualitative research does not work, perhaps for ethical or practical reasons. We need to develop new methodologies and encourage students to be able to do that kind of thinking so these new methodologies arise as their careers develop.

We also need to try to achieve a balance between students being critical, being committed, and being pragmatic. This comes from some thoughts that Jack Shonkoff shared with us. Each of these perspectives has to be balanced in order to integrate research, service, and advocacy successfully. If you do not have a commitment to something and cannot think pragmatically, you are not going to be able to conduct research that integrates these three perspectives.

The final point I want to make is that training should try to help students identify and focus on big problems in society, as well as the small ones. We need to take both perspectives, because if we just focus narrowly on a particular child, for example, or a particular situation, we sometimes mask the bigger problems that might be interfering with the success of an intervention. Identifying big and small problems has to occur within a very important context, however. That is the context of helping students to clarify their own values, political orientations, religious

viewpoints, and attitudes they have developed early in life.

An example of a very big problem that we need to address in society is the problem of racism and the impact that it has on the quality of all of our lives. A smaller problem is the problem we are talking about today: how to educate our university students. Even smaller problems might be things that are happening within my own community that I am concerned about, such as youth development and teen pregnancy.

What are some of the elements of training that we need to put in place to address some of these skill objectives? First, we need to teach knowledge utilization rather than focus so much on knowledge acquisition. We know that policy makers, as was pointed out, often do not use social science research and that social scientists do not often know how to translate their research into a usable form. So, the question is, is there anything we can do about this in university-level training?

Second, we need students to engage in value clarification and to link their value-oriented thinking to problems and solutions. In order to do this, we have to get them to identify what they are passionate about, what they are committed to, and how this is fundamentally built on their own values. We cannot ignore that in translation. Otherwise, these later integrations are not going to be possible.

Third, we need to encourage students to have real opportunities to use multidisciplinary approaches in problem solving. In psychology, we have to begin to think much more broadly. Let me offer a personal example. In my work in the community health intervention, I greatly benefited from a very specific training in measurement in psychometric psychology and also in evaluation design. However, I had to be familiar enough with behavior modification techniques and know how these other disciplinary perspectives could help me with quality control of the social work and clinical work that we were doing in this particular setting in order to be successful. I had to broaden my thinking.

The fourth element we need to have in training is an enhancement of communication skills, especially oral presentation and writing for lay audiences. We continue to see some very bad examples of how to present our ideas and findings. I was lucky enough in this particular intervention to have a couple of board members that kept pushing me to write materials for lay audiences and helped me put pictures in them. I have probably received more requests for a book I wrote with pictures and photographs that talked about the lessons we learned—what worked and did not work—, which is not a research publication, than I have ever received for anything that appeared in a journal.

We also need to focus our attention on issues that relate to training. I have heard a lot of discussion about issues that concern us in Head Start programs related to training staff and the quality of staff. Research training also needs to focus on the importance of quality control and on what contributions research training can make to help professional and staff development. There are a number of ways in which my research training helped me to generate methods and systems that were very supportive of the quality of the service that was delivered in our intervention. We do not stress this strength enough in our research training.

Finally, we need to expose students to training models that have experiential and collaborative learning as components and do this in a workshop format. My colleague, Celia Fisher, will give us more detail about that kind of learning. The Harris School at the University of Chicago uses a public policy workshop that provides a model of experiential policy training, which other faculty, developmental faculty in particular, might want to consider. Supervising faculty draw on their ties to the community in the policy world, particularly to structure certain policy problems that students have to solve by developing projects with local policy makers, service providers, and clients of the particular project. These interactions produce the experiences that students need in order to learn how to solve difficult social problems, either in the service arena or the public policy arena.

At Michigan State University, I have heard a lot about how the university acts as a broker to

link faculty expertise. This provides opportunities for students as well by allowing them access to laboratories in the real world that they can use to produce knowledge utilization, rather than just reflecting back acquisition. This fosters the opportunity students need to practice communicating, teamwork, and collaborative thinking and leaming; to conduct policy analysis; and to combine analytic judgment with creative and practical thinking.

Where does one get such training? Graduate training is going to have to get off the campus. Students are going to have to be oriented to a semester on campus and a semester off campus, as they do at Antioch and other undergraduate colleges, at the graduate level. Students will have to visit public policy institutions and work in the field. We are going to have to create opportunities for faculty to leave the university and to be in situations where they can then have students work with them. I want to refer you to the SRCD Social Policy Reports on training and opportunities for developmental scientists with applied interests. There are several papers, including a paper by Sussman-Stillman in 1996 with a graduate student perspective on training and career options. Fisher and Osofsky wrote a paper in 1997 on applied developmental programs within psychology departments and medical schools. Gordon and Chase-Lansdale also wrote a paper in 1997 on public policy schools as opportunities for developmental scientists.

Finally, we are going to have to change the structures of universities in order to make this possible. It will not happen otherwise. I think we have to hire different kinds of people in universities if we want to make appropriate linkages with communities. We are going to have to have people helping faculty do this, and they are going to have to be within the university. There are a lot of departmental changes that may need to happen as well.

Celia Fisher: First, we do have a new journal of applied developmental science, and we welcome people who are writing and exploring the interface between science and application and universities and communities.

My presentation is very specific, because I knew there were going to be many comments on the general goals of applied developmental programs. I will talk specifically about the practicum experience and how important it is to get scientists into the community. I am going to do so from our 10 years of experience with doctoral training in applied developmental psychology at Fordham University, and in particular with the applied developmental psychology practicum, which was developed by Nancy Busch-Rossnagel, Mary Ann Lewis, and Anne Higgins D'Alessandro.

At Fordham University, students take the applied developmental psychology practicum in their third and final year of didactic training. They do this so that they can not only gain experience from the practical side, but also so they can serve as developmental specialists and consultants. Practicum sites are Head Start programs, elementary schools, high schools, foster care agencies, psychiatric hospitals, women's shelters, shelters for the homeless, and child care agencies.

Our first 2 years of didactic training are very intense because we are training a student to be both a scientist and a practitioner as well as trying to train them to be able to consult with community members. Thus, they receive extensive training in basic developmental, social, cognitive, and emotional processes, emphasizing individual and cultural differences as well as normative and atypical processes. They take courses in research and statistical methods. They have to be involved in at least two research programs throughout the first 2 years. Then, they take program design and evaluation, so they can conduct outcome research at real world sites. They also take several courses in developmental assessment, neuropsychology, cognitive psychology, personality, and family.

They also take other application strategies, including behavior modification and community consultation. In their third year, when students are doing the practicum, they are simultaneously taking additional assessment and statistical courses as well as a course in professional ethics, social policy, and psychology. It is difficult to train someone in all of these skills. Our students

have only one elective in all 3 years of their program.

The purpose of the practicum is to take all of the didactic experience and research knowledge and apply it to the real world to try to decrease the intellectual and social distance between basic and field research and between science and application. The practicum demonstrates to the student how the biological, ecological, and cultural influences that they have been reading about actually operate and are perceived by community members themselves. I think that addresses some of the issues that Gertrud Lenzer was talking about. The practicum also has students work with community partners to broaden their understanding of whether or not the extant knowledge actually generalizes to the problems that practitioners and communities are facing. The practicum also helps students understand the multiple roles that they will play when they get out in the real world from a colearning model. They will be teacher and student, the guide and the guided.

We see the applied developmental practicum as a crucible for community training. The practicum helps students to understand the dynamic qualities of communities. Our students get their first experience with their practicum sites in the second year when they speak to their prospective supervisor and develop with faculty the goals of their practicum. However, by the time they get to their site a few months later, the administrator could have changed. The financing and funding at the site could have changed. There are so many changes that could have taken place that their whole project could now be different.

Another aspect of the practicum is that it helps to identify natural barriers to entry into the lives of the communities. For example, after discussing with an administrator how wonderful the project is going to be, the student gets to the site and realizes nobody informed the staff or the staff is in total rebellion or has no time for this project to be implemented.

This leads to a third experience students have at a practicum, which is learning how to negotiate across bureaucratic boundaries, for example, having relationships with foster care agencies and trying to figure out who is a guardian. Where do you get permission to do certain interventions or evaluations?

The practicum also allows students to understand cultures, languages, and norms of communities, not just from a book, but with dialogue and sometimes with confrontation when values are seemingly in conflict. The practicum also helps the student test and strengthen their self-definition as a developmental specialist. Any practicum site is going to be multidisciplinary. Our applied developmental psychology practicum helps the student to appreciate the unique skills that they bring to a site and how it complements the unique abilities of other clinicians, nurses, social workers, and parents.

Another aspect of the practicum is that it helps to sustain university-community partnerships, the reason being that a lot of times when we as academicians go into the community, we do so because either we have a grant or the site has some money. Our relationship is thus limited by that funding. However, a university-community partnership that is part of an ongoing curriculum where there is an influx of students each year can weather the ebb and flow of those funding problems.

The practicum also provides stakeholders. Many times a student can bring to a setting knowledge about best practices for certain types of interventions. They bring empirically valid means of assessing intervention outcomes. They can bring information and skills in terms of surveying who will and will not benefit from a particular program and how to increase usage.

Developing a practicum is a lot of work. Our practicum faculty work very hard. First, they have to identify and form relationships with sites. We have some relationships with sites dating back at least 10 years. However, we are always nurturing new sites. This requires constant visits to a site or a faculty visit at least once a year. It requires constant phone calls with sites. Another requirement of the practicum is to match sites to students. This requires knowing what the student's career goals are and the types of populations that they want to study and service once they get their Ph.D., as well as assessing their strengths and what they can offer the practicum site.

A third element is establishing program structure and supervision at the site. People are very busy at a practicum site, and convincing them and having dialogues with them in terms of the mutual benefits of supervision is important.

All of our students spend approximately 12 hours a week at the practicum site and must meet at least once a week with an onsite supervisor. In addition, they receive 2 hours of supervision a week at Fordham with the practicum faculty. They meet as a group and discuss their research methods in terms of the outcome studies that they are doing at the site. They forge their identities and talk about the challenges and frustrations of being in the real world. In addition, to be fair to students and to sites, fair and informative evaluation procedures were developed. We have written evaluations of both the sites and our students twice a year as well as oral feedback.

An issue dear to my heart is training students for the ethical responsibilities of a scientist-practitioner engaging in community-university partnerships. The practicum provides an opportunity to educate students about the need to make sure the practicum sites and communities understand what university projects can and cannot do in order to avoid unrealistic expectations. Some of those unrealistic expectations usually entail the sites' desire for immediate benefits when sometimes the program is going to offer long-term benefits.

Another issue is that students are eager to use all of their empirical methods. So they are applying measurements that give quantitative results. At the end of the outcome project, the administrator will say, "But what is my staff doing? What do they say? What do these numbers mean?" We have to discuss with practicum sites both qualitative and quantitative data. Another issue is the need for control groups. There is great resistance at many sites for control groups. They feel they are depriving people of services, even those services that have not yet been tested. A lot of dialogue is required in terms of the extent to which a control group is necessary and what is the best type of control group for the particular site.

Another ethical issue that arises is informing people about the potential risks that are involved in research. Are you going to find a lack of abilities among staff that was not noticed before? Is there a greater risk for clients that abuse reporting because of greater screening?

Another issue is parental consent. Many of us have gone to some practicum sites where the administrator will say that you do not have to get permission because parents signed a waiver when they came in. However, it is the ethical responsibility of the applied developmental scientist to check out what was written, check out whether or not what we are now introducing was actually covered in that form, and also be able to check whether the person who signed the form is still the guardian, because that is not always the case.

Another ethical responsibility is to think about referral activities. When we go into a site, we may do a developmental assessment that identifies a risk that the site itself is not capable of treating and, therefore, prior to our using these assessments, we should work with the site to identify external and other types of services if we do identify a risk.

A very important ethical responsibility is identifying the potential iatrogenic impact of both participant recruitment as well as dissemination. For example, what does it mean if you go into a school and you want to run a prevention program for aggressive children to prevent delinquency in the future? What does it mean to identify these children as potential delinquents? What does it mean to the children and their families? How are they going to be treated by teachers? What happens with dissemination? Even if the program was a success and the findings are published, suddenly the parents are reading about their children's weaknesses and may be devastated by the description. In addition, we also have to educate communities that sometimes our outcome research will not always be positive and, therefore, prepare them for that possibility. An important part of outcome research is that it be designed to improve and not destroy programs.

We conclude our practicum experience with a session hosted by our practicum faculty. All of our developmental faculty members attend. Participants also include the practicum students and their site supervisors as well as second-year students who come to see what life will

be like in their third year. The site supervisors and students jointly describe their experiences. Faculty members ask the site supervisors to describe the strengths with which our students came. We ask what additional curriculum issues we should be building and what skills our students did not possess. It is a wonderful opportunity to use the community as a way to strengthen and build our curriculum so that we are educating students for the careers that they want and the communities that they serve.

Hagen: First, I wanted to mention the unintended effects of our work in universities. About 10 years ago I was skiing in Northern Michigan. A young man came up to me and said, "I know you're Professor Hagen. You don't remember me," and I did not. He introduced himself as a former student of mine. Once I remembered him, we talked about his previous work in an institution for mentally retarded children. In our conversation, he told me he had then gone on to law school and was now a chief prosecuting attorney. I asked him if his psychology major and the work he had done had an influence in his current profession. He replied it had a profound influence and that he had been chairman of the local community mental health board for a number of years. He also had done some major reforms in the way that youth were incarcerated in their county jail. I realized that we often have an influence that we may not realize. I am sure that many of us have had that experience.

We need to realize that there are a number of dilemmas facing us right now. Some of these came up either explicitly or implicitly. One thing we have to ask ourselves is, "Where are we going to find the faculty and the trainers for these new kinds of people?" Most of us were not trained that way. I agree completely that we have to move out of universities and into the field. Yet, many of us are not very good at that and may not even want to do that. We went into these fields because we like doing certain work and the ivory tower in the laboratory has a certain appeal.

Another thing that we need to think about is the kinds of students and the kinds of things that are happening in our field. I think there are some real issues and dilemmas. I have been looking at the Journal of Child Development and some other journals in terms of tracking trends of published research on many topics. We know that over the last several years, there has been an increase in published research on children of minority backgrounds, which is positive. However, we are getting fewer minority students enrolled in programs now. Frances Horowitz is trying to address that directly at SRCD.

Also, many of us in the field have seen an increase in the proportion of male students to female. However, in the last few years most of our graduate students are females. Yet, the males not going into the developmental psychology and sciences fields are going to become the fathers, lawyers, and teachers of children. Another issue causing dilemmas in our field is certification and licensing. We need to develop strategies to deal with certification at the state and local level—the level of the profession.

Miscellaneous

Milton S. Eisenhower Foundation
A Thirty Year Update of the Kerner Riot Commission

PRESENTER: Lynn Curtis

Lynn Curtis: This is an update of the National Advisory Commission on Civil Disorders and the Kerner Riot Commission that produced this report in the middle of the riots in 1968. I am president of the Milton Eisenhower Foundation, a private sector continuation of the Kerner Riot Commission and the National Violence Commission. Both commissions were created by Lyndon Johnson in the late 1960s when all hell was breaking loose. I will be showing two videos: one from NBC and one from the NewsHour with Jim Lehrer. These two shows include panelists who agree with my views and those who disagree.

The theme of this session embraces both research and practice, the focus of this conference, but also includes a discussion of the importance of the media. I think that researchers and practitioners need to be much savvier about the media because all three of these themes converge. I will illustrate this by using the 30-year update of the Kerner Commission as a case study. This update was issued March 1, 1998, 30 years to the day that the Kerner Commission issued its report. This is not very focused research, with a sample size of 12, but it essentially demonstrates how policy for the inner city and the truly disadvantaged can proceed.

The following is the NBC broadcast on the Nightly News, Sunday, March 1, 1998:

> **Jack Ford:** In focus this evening on NBC Nightly News is the update of the 30-year-old Kerner Commission Report on Race and Economics in America. The new version lists many of the same problems. Details now from NBC's Joe Johns.
>
> **Joe Johns:** From 1964 through 1968, more than 250 American cities erupted in violence. They were the worst riots in U.S. history. Nearly 300 people died; 8,000 were injured. Property damages were in the hundreds of millions of dollars. New civil rights laws had banned discrimination but had not put an end to racism.
>
> **Man:** We want freedom and justice and equality. We want to be treated equally.
>
> **Joe Johns:** Many of the big cities, which burned in the 1960s, still bear the scars today. President Lyndon Johnson, concerned that extremist groups and perhaps even communists were organizing the disturbances, appointed a commission to investigate.
>
> **President Johnson:** Let your search be free. Let us be untrammeled by what has been called the conventional wisdom. As best you can, find the truth.
>
> **Joe Johns:** The Kerner Commission delivered its truth after 8 months of study. The violence, it stated, was not the product of a conspiracy but the product of frustration. The report described high unemployment, low family income, poor schools, bad housing, and mistreatment by police. It issued a stern warning that an underclass was being created along racial lines: a nation moving toward two societies, one Black, one White, separate and unequal.

Man: That is more or less becoming true again today.

Joe Johns: Former Oklahoma senator, Fred Harris, was a member of the Kerner Commission. He helped write a 30-year update for the privately funded Eisenhower Foundation that was started to continue the work of the Commission.

Man: Things got better in regard to race and poverty and the problems of the inner cities for a good while after the Kerner Report, up to about the end of the 1970s. Then that progress stopped and in many ways, began to reverse.

Joe Johns: The new report found that there is more poverty in the U.S. than there was 30 years ago and that unemployment among African Americans is more than twice the national average.

Man: The saddest thing of all about it is that there has been so little done.

Joe Johns: To change the trends, the new report recommends establishing national programs modeled on local ones with proven track records.

Man: If we just take all those programs that have already demonstrated success and combine them, we would have a coherent policy.

Joe Johns: One example is the New Community Corporation in Newark, New Jersey, which offers a broad collection of services to thousands in the inner city every day. It operates daycare centers that serve about 900 children daily. It provides security-patrolled housing for about 7,000 residents, provides job training for inner-city teens, and even creates jobs in its own shopping center, complete with a grocery store and restaurant.

Monsignor William Lynner founded the program 30 years ago in the months after the Kerner Commission Report was released.

Monsignor Lynner: We need to take the lead and find the solutions.

Joe Johns: The update to the Kerner Commission Report cites the significant expansion of the African American middle class and it recommends new laws and federally funded programs to help end the cycle of poverty for those left behind.

Man: This is a report that thinks more government action is going to be the solution to all our problems.

Joe Johns: Copies of the report will now be delivered to members of Congress and the White House but the authors say they do not believe the changes they recommend will be made.

End of Broadcast

Curtis: As you saw in the video, we found that there has been considerable progress in the last 30 years. The focus was on the African American community because that is what the original Kerner report talked about. One can find a growing African American middle class and one can find improved performance in high school among African Americans in terms of completion rates. There is certainly an increase of African Americans in public office.

There have been a number of very positive trends that one sees as over the last 30 years. We found more negatives though and that is where some of the media debate has ensued. For example, while our leaders today boast about a full employment economy, with unemployment rates below 5%, in many inner cities we continue to find depression levels of employment. In South Central Los Angeles 6 years after the riots, the unemployment rate for young African American men is well above 30%.

During the 1980s, we had a policy in which tax breaks were given to the rich. Specifically, the income of the richest 1% increased by 120%. The income of the poorest fifth in the country

decreased by 10%. As the conservative Kevin Phillips has said, "the rich got richer and the poor got poorer—but the working class also got poorer and the middle class stayed about the same, which meant that the middle class lost ground to the very rich."

We know that child poverty increased by over 20% in the 1980s. Today the United States has the greatest disparity in wealth and income of any industrialized economy and the disparity is growing greater faster than any other country. The same thing can be said for wage disparity. Twenty years ago, a CEO earned 35 times as much as a worker, today a CEO earns over 180 times as much as a worker.

Based on the research of Garry Arfield and others, we know that segregation in schools and in neighborhoods has increased. We know that today two-thirds of inner city children are performing below basic standards on national tests. We know that appropriations for housing over the 1980s were reduced by 80% at the same time that we tripled our number of prison cells. So in some ways our national housing policy for the poor has become prison building.

Similarly, we know that states now spend more on building prisons than on building institutions of higher education. Ten years ago that was not the case. We know that today the rate of incarceration of African American men in the United States is four times higher than the rate of incarceration of Black men in pre-Mandela apartheid South Africa. We know that the prisons are filled mainly with those people associated with drug crimes. We also know though that prison sentences for those involved with crack cocaine are far longer than for those involved with cocaine in its powder form. Of course poor minorities disproportionately use crack cocaine and the suburban White population disproportionately uses powder cocaine.

Finally, we know that based on the best study by the National Academy of Sciences, the criminal justice response to violence is at most running in place.

When we put all of these economic and racial statistics together, we found that there were at least two breaches in our society and that is why we called our report the "Millennium Breach." One obvious breach is between those locked in the inner city and in pockets of rural poverty and the rest of us. The other relevant breach we thought was between the truly disadvantaged, the working class, and the middle class on the one hand and the "super rich" on the other hand. The super rich were those who benefited from all the supply side policies of the 1980s and early 1990s.

We then asked in this update, What research-based policy is needed for the truly disadvantaged in the inner city, in response to where we are now, to close these class and racial breaches? To answer this question, we need to remember what the polls said after the 1992 riot in Los Angeles.

The New York Times and CBS did a national poll and asked people whether they were willing to do more about poverty and race in the inner city. A majority of Americans said they were willing to do more even if it meant raising taxes and spending more of their tax dollars. The next question in the poll was what is the major obstacle to doing more and a majority of Americans answered that the major obstacle is lack of knowledge. That is a very relevant comment to this conference.

The typical American believes that we do not know what to do. That is not true. In fact, we know a great deal of what does not work and we know a great deal about what does work. It would seem to make sense for national policy to stop doing what does not work and invest the money so saved into what does work, and to replicate what does work at a scale equal to the dimensions of the problem. I am afraid that is much too rational a policy for Washington.

I want to give you some examples of what does not work, then some examples of what does, and then move on to talk about politics in media. What does not work certainly includes supply side economics. It is voodoo economics and only the very rich benefited from it. Enterprise zones as originally described have also been conclusively shown, for example by research at the Urban Institute, not to work. The Job Training Partnership Act, our main way of training out-of-school youth, has failed for that very group. Research done at the University of Maryland shows

that boot camps have not worked.

Accompanying these failing polices that were promulgated in the 1980s were many buzzwords, such as coalition and partnership, self-sufficiency, and above all, empowerment. These are words that we all use if we are practitioners working in the inner city but we have found that often they are camouflage, smoke screens used by politicians who do not have the money to replicate what works to scale or who are actually disinvesting.

We also thought in the report that there is a moral dimension when looking at what does not work. It really is immoral to give to the rich and take from the poor. It really is immoral to have a national housing policy based on prison building. It really is immoral to spend more on prisons than on higher education. I do not think we have stressed the moral argument enough—juxtaposing it against the facts that we have learned from research. One can, however, take the moral high ground against the naysayers who essentially argue that nothing works.

So much for examples of what does not work. There are far more examples of what does work. One can begin with Head Start and I do not have to talk about the research on Head Start at this conference. I do, though, tend to quote studies by conservatives who say that Head Start works. When trying to persuade citizens that Head Start is indeed a cost-effective policy, quoting a study done in 1985 by The Committee for Economic Development in New York has had more impact than if one quoted studies by liberal academics.

An evaluation done by Columbia University shows that for older children Safe Havens After School, where children go for support and discipline, help with their homework, and some food, work. There are several other evaluations of Safe Havens After School by the Eisenhower Foundation and others that agree with the Columbia evaluation. There are examples of public school reform that works. The Comer School Development Plan is one obvious example, where teachers and parents and principals are taking over inner city schools. Professor Comer is on our board. One of our trustees, Joy Dreyfus, has just written a book called *Safe Passages*, that talks about full-service community schools. We need to have a commitment to saving our public schools and not the alternative voucher-type schemes.

An evaluation done by Brandeis University shows that for high school students the Ford Foundation's Quantum Opportunity Program, which is based on mentoring, has worked. For dropouts, we know that the Argus Learning for Living Center in New York is a good example of a training program that gets dropouts back into constructive jobs. I raise Argus as an example because it is training first. Argus assumes that dropouts or people receiving public assistance need basic remedial education, life skill training, and other job training before they actually get placed. Training first models are not popular today since almost all the money that is available is for work first programs. We predict that work first programs will be as unsuccessful as JTPA for out-of-school youth.

Community Development Corporations (CDCs) like the one in Newark can generate jobs. Those were begun in the 1960s by the Ford Foundation and actually by some of the work of Robert Kennedy in Mobilization for Youth. To finance nonprofit CDCs, we know that community banking based on the South Shore model where savings of poor people are kept in the neighborhood works. We know that community-based policing works—where police officers are in the neighborhood, and police stations are on every fourth street corner. This is modeled after the Koban system in Japan.

When one looks at examples of what works the feature that stands out most is how they interrelate. Community-based policing, for example, can help stabilize a neighborhood to encourage community-based banking, which can encourage Community Development Organizations, which can generate jobs for higher risk children, who can qualify if they are in Argus-type training. Similarly, a program like Quantum Opportunities can keep children in high school. They can get that far if they have been in the Safe Havens and Head Start programs. When one looks at what works, one can these see these interconnections and what Lee Shore at Harvard calls multiple solutions to multiple problems.

We think that the private sector should finance such a policy, if possible. We think it is more relevant to observe historically that the private sector has never really come to bat on these issues and that the only institution that is capable of replicating at a scale equal to the dimensions of the problem is the federal government.

We have taken all these examples together and we have said that our policy essentially is based on the reform of public schools in the inner city combined with full employment. Reform of the school system begins with full funding of Head Start for all eligible children, then goes on to work in inner-city schools by replicating the models of success that we already have like the Comer plan, and the full-service community schools that are documented in Joy Dreyfus' report.

We also say that education is only one part of it. A full-employment policy in the inner city is another part of it. We are only talking about roughly 2.5 million jobs. That is not really very many in this level economy. How are those jobs created in the inner city? Using existing federal resources but better targeting them to poverty reduction can do some of it. In a study done by the League of Cities, local officials were asked whether economic development money from the federal government was being used for poverty reduction. Only 10% of the local officials said that was the case—that is, we are not using economic development grants for reducing poverty.

If we better targeted our existing money and we got a community development bank that promoted private sector entrepreneurial activity, we could do a great deal towards supplying those 2.5 million jobs. We also call for public service jobs, jobs that repair the urban infrastructure, jobs that build housing for the poor like Youth Build USA does, jobs in child care for mothers receiving public assistance, and jobs that help those receiving public assistance find work. There are untold opportunities in public service employment and public works employment.

We also talk about how policies of racial and criminal justice should support this emphasis on education and employment. We talk about affirmative action and we say it needs to be continued. We also talk about policies that are successful in integrating our schools and integrating our neighborhoods. However, we have the racial justice policies in a supportive role because we find that education and employment reform resonates better and is the leading policy to pull people out of poverty and address what is happening in the inner city.

The funding can be by the federal government and must be but we are talking about implementing much of what works through the private, nonprofit sector as much as possible. Much of what works, based on existing research, is in the private, nonprofit sector. This will require federal leadership. It will require the kind of commitment to effective government that Franklin Delano Roosevelt had and it will also require boldness in establishing the limits of corporate greed that Theodore Roosevelt manifested.

That brings us to discussing how to finance our policy, which would be $56 billion per year to fund primarily education and employment programs. We do not talk about new taxes; we talk about a $1.7 trillion federal budget and about shifting priorities within that budget. There are two main sources of shift that we discuss. We want to take money from affirmative action and we want to take money from public assistance. More specifically, we want to reduce affirmative action for the rich and reduce corporate welfare.

Today we taxpayers spend over 100 billion dollars a year on tax breaks to corporations, tax breaks for the rich, and subsidies for corporations. We plan to reduce that and shift it more into the priorities that we have set forth. Any review of some of the subsidies we give to the corporate world is most amusing. Reich did it in his book *Locked in the Cabinet*. He gave good examples. One of my favorite examples of current subsidies is a grant that the federal government made to the Disney Corporation to produce better fireworks in Orlando. One could argue that that is probably not as important for us to do as Head Start for poor children.

We also talk about financing what works through any budget surplus that emerges, and from reductions in military spending. Our question is: If we do not do this now when we have a robust economy, will we ever pursue a policy of full employment for the inner city and public

education reform? That is more than a rhetorical question because it has to do with our national political priorities. Will any of what we are recommending happen soon? You heard the Republic Congressman say at the end of the NBC tape that it will not happen soon because the problem is not so much the boys in the hood as the boys on the hill.

Today Congress is getting it backwards. Congress over the last several years has been trying to expand what does not work and trying to reduce what does, like coming up with new schemes of tax breaks for the rich and supporting prison building. On the other hand Congress is attacking programs that have shown worth and need to be expanded, such as Head Start. A few years ago, Head Start was under a lot of criticism. One of the criticisms was, for example, that children make some progress when they are in this program but then when they get out, the gains decrease. Of course that is going to happen if children are thrown back on the mean streets and there is not an interrelated set of multiple solutions where, for example, they go from Head Start to the Safe Havens After School, to the Quantum Opportunities program of the Ford Foundation. That is an easy one to knock over when the naysayers are attacking Head Start.

It is also true that Congress cut money for the management of Head Start programs and then accused Head Start of not managing its programs well. All of this, of course, is typical Alice in Wonderland policy by the Congress. Overcoming that policy is not going to be easy. It means first of all recognizing that the economic system runs the political system in America today. We do not have a one person one vote democracy; we have a one dollar one vote democracy. The implication is that we will never be able to replicate what works based on good science to a scale equal to the dimensions of the problem unless we have real campaign finance reform and control of the lobbyists who are zooming all around us here today in Washington.

Reform will allow many of the other reforms to proceed. A great example of how this all works played out recently. Originally the report said that funding for some of what works should come from the tobacco settlement. The tobacco settlement went up in smoke, as you all know. Why did that happen? It went up in smoke because the tobacco industry mounted a $40 million advertising campaign. That amount is cheap for the tobacco industry but it was very successful. They reframed the debate from health for youth to big government. That is exactly what was done when Clinton proposed health care reform; the opponents talked about big government.

The media sophistication of the tobacco industry and the health industry and many of the other big industries that are getting subsidies today means that we will really never be able replicate what works until we get more sophisticated with the media. I want to talk briefly about how research policy and media overlap. We really need a national movement to communicate what works.

Here is a little history. After the defeat of Barry Goldwater in 1964, the conservatives set off on a well-thought through plan to communicate their message. Today there are many conservative foundations, like the Bradley Foundation in Milwaukee, pumping millions of dollars into conservative think tanks for media and communications. The largest, most effective conservative think tank in media and communications is the Heritage Foundation. They have 60 people writing policy analyses at any one time. An analysis is on the desk of every member of Congress the next day. There are op-ed pieces placed in newspapers every week by this Foundation. Perhaps more significantly, Heritage has a TV studio on its premises, which means that Heritage associates like Ed Meese can go down to the studio and practice their 7-second sound bites and hone their electronic media skills before they go on Ted Koppel.

On the other hand, progressive foundations have been very reluctant to fund communications and media. Why? Mainly because progressive foundations have thought that it would be a violation of the nonprofit status of organizations to get that kind of money. They feel that this would be engaging in advocacy, a violation of their nonprofit status. The conservatives do not worry about that. They just go ahead and pump the money in and no one seems to care and no one seems to question them.

There is also collusion between the naysayers and the media itself. We need to review how people get the news. Most Americans do not get their news from the newspaper; they get their news from television, not from Ted Koppel or Peter Jennings on the national news but from the local news in their own town. Americans trust the local news and their local anchor people. These local television stations tend to be controlled by the seven multinationals that control almost all media in the United States. For example, who owns more television stations than anyone else in the United States? It is Rupert Murdoch, the conservative Australian. The sale of commercial time is used to maximize profits for the local news. They get commercials and they want people to watch those commercials. How does one get them to do that? For better or for worse, local television managers think that the philosophy should be, if it bleeds it leads. What local television managers will do for the most part is lead with the day's rapes, murders, and bad news, as well as the demonization of minority youth and the demonization of women receiving public assistance. As George Gerbner, Dean Emeritus of the Adam Brooks School says, this can create a mean world syndrome. People living in the suburbs see this endless parade of negative news night after night and they get a sense that nothing works, that the naysayers are correct, and that the only solutions are the negative ones like prison building. We need to change all that.

The Eisenhower Foundation is trying to start a "communicating what works" movement. We are trying to work with other national nonprofits. What we have done is start a television school for nonprofit grassroots community leaders where they first have to give their message on camera and they sweat and squirm and are worried and nervous but they do it. This is played back in front of their friends and their colleagues. It is amazing how this process, while anxiety provoking, results in quick learning by grassroots leaders.

It is going to take a while but in response to this, one of the things we will be doing is saying, "If you are going to issue a national report like our 30-year updated Kerner Commission, make sure that you get really good national media coverage." We have been able to do that. I showed you NBC, and now I am going to show you a broadcast of the NewsHour with Jim Lehrer.

NewsHour with Jim Lehrer:

Commentator: Now, an update on the Kerner Commission Report. Thirty years ago in the wake of the urban riots of 1967, a presidential commission headed by then Illinois Governor, Otto Kerner, concluded that the nation was "moving towards two societies: one Black, one White, separate and unequal." That prediction has come true according to a new report from the foundation set up to carry on the Kerner Commission's work.

The study concludes the economic and racial breach is wide and growing wider with America's neighborhoods and schools resegregating and child poverty up over 20% in the 1980s, a situation that disproportionately affects minorities.

We get four views now on the new report. Lynn Curtis is the president of the Milton S. Eisenhower Foundation and one of the authors of the new report. Hugh Price is president of the Urban League. Robert Woodson is the president of the National Center for Neighborhood Enterprise and Steven Thurnstrom is a professor of history at Harvard University and the co-author of "America in Black and White, One Nation Indivisible: Race in Modern America". Thank you all for being with us.

Mr. Curtis, the Kerner Commission was set up to look at the riots of the summer of 1967 and the summer before, riots in which 100 people died and many hundreds were injured. What was your report looking at specifically?

Lynn Curtis: We looked at what has happened in the 30 years since the original Kerner Commission Report came out. What we found was that there has been good progress in many areas. For example, the African American middle class has increased and high school graduation rates for African Americans have improved. We also found that there have been a lot of negatives. For example, employment in

inner cities is at depression levels at the same time that we celebrate a supposedly robust economy. The rich have been getting richer at the same time that the poor have been getting poorer or the working class has been getting poorer. The middle class has also lost ground to the rich.

You mentioned the increase in child poverty. The US child poverty rate is four times higher than in Western Europe and today, the rate of incarceration of Black men is four times higher than in pre-Mandela apartheid South Africa.

When you look at income, wealth, and wages, and when you look at employment, education, and the bias of the criminal justice system you see a growing breach and that is why we have said on balance, things are getting worse.

Commentator: Mr. Woodson, what do you think about those conclusions?

Robert Woodson: I do not agree with the conclusions. He makes this race and economics. The biggest income gap has been between low-income African Americans and upper-income African Americans. What he fails to address in the report is if racism is the primary contributor to the problems of poverty, then why is it that poor African Americans suffered over the last 20 years in cities where the programs are run by African Americans? We have the highest per capita expenditures to aid the poor through school systems, foster care systems, and housing programs in some of those cities. Yet an African American child born in Washington and Harlem has a lower life expectancy than does a child born in Bangladesh or Haiti.

So the point does not really address, if racism is the primary contributor, why African Americans are failing in the hands of other African Americans.

Commentator: Did you conclude that racism was the primary problem?

Lynn Curtis: No. We concluded that poverty and race are intertwined and I will respond to Bob in this way. In the late 1970s when I was working with the Carter administration, I gave Bob a grant. It was to start up his own organization. It was a federal grant to empower him to invest in human capital. He has done very well.

We are saying in this report that we need to invest in the education and employment, not only in the poor but also in the working class and the middle class.

Commentator: Let me come back to both of you on what should be done in just a second. But first Mr. Price what do you think about the conclusions in this report?

Hugh Price: I think the United States is not the racial cauldron that it was 30 years ago because we have made a lot of progress. Corporate work forces are vastly more integrated as are college campuses. The middle class has grown. However, the United States in 1998 is not the melting pot that it ought to be because we do have tremendous stratification along skill lines that affects minorities disproportionately. We have a huge achievement gap in our society. We have serious pockets of deep unemployment in poverty and we therefore have a long way to go but we have certainly come a long way from 1968.

Commentator: Do you welcome this report? Do you think it is necessary?

Hugh Price: I think the report is necessary because it enables us to take stock some 30 years later. It points the spotlight on areas that still need attention, such as the prison system, the continuing conflicts between police and civilians, and the pockets of high unemployment and hopelessness. We certainly need concerted action there. I think the report does undersell the progress that we have made, which has been quite significant.

Commentator: Mr. Thurnstrom, what is your reaction to the conclusions of the report?

Steven **Thurnstrom:** I think it is deja vu all over again. The Kerner Commission Report itself was a quite unbalanced and simplistic analysis of the social trends in the 1950s and 1960s, and was quite mistaken in many ways. It unfortunately created a tradition of doom and gloom and simplistic analysis which, after the 5th anniversary, the 10th anniversary, the 20th anniversary, all provoke much comment unfailingly stressing that nothing has gotten better, indeed things have gotten worse.

Now the Eisenhower Commission report is not quite as simplistic as that but it does seem to be rather lurid and misleading in fundamental ways. For example, it stresses wealth disparities with some figures I find impossible to verify. It claims 1% holds 90% of the wealth. The latest Census Bureau study of this shows that the top 20% own only 43%.

More important, in terms of the stress on continued African American child poverty, that is indeed true and very alarming. The question is what is causing it. We know in fact that it is very closely linked to the fact that 70% of all African American children today are born out of wedlock. There is an enormously close correlation between being born out of wedlock and growing up without a father in the household and being poor. Indeed, 85% of all poor African American children today are living with their mother and no father. This is a problem. I would strongly stress that this obviously would not be ameliorated one wit if every White racist dropped dead tomorrow.

Commentator: Mr. Curtis you want to respond to these and specifically that criticism?

Lynn Curtis: I am a graduate of Harvard and I have learned not to listen to Harvard intellectuals as much as my mother or David Letterman's mother. I find some of those comments simply not in keeping with what the statistics actually show. I would ask the professor to talk to his colleague at Harvard, William Julius Wilson, who has many of the statistics we used.

Commentator: What about the point about the family structure?

Lynn Curtis: The most important point in our report is that unemployment is at depression levels in inner-city areas. When you have unemployment, families fall apart. You have a social structure that is not in existence. With a full-employment policy, a lot of other things will follow.

Commentator: So let me get this clear quickly. In looking at these problems which you enumerated, the main cause is unemployment. What other causes do you look at in the report specifically?

Lynn Curtis: The main policy is full employment in the inner city along with reform of the public inner-city school system. The causes of this go way back for example to the 1980s when the administration practiced tax cuts for the rich and that resulted in the poor getting poorer, the working class getting poorer, the middle class losing ground. Those are the causes.

Commentator: Let us look at causes now, Mr. Woodson. What do you think the causes are of some of the problems or do you not think there are some of the problems that were enumerated?

Robert Woodson: First of all, I think it is fantasy for Lynn to say that he gave us the money to start the organization. It is just patently untrue as are elements of the report.

For instance, if economics, full employment, and race conditions were the sole predictor of a people explain to me why during the 10 years of the Depression,

82% of African American families had a man and a woman raising children when there was 25% unemployment and 50% in the African American community? He almost exempts the poor from the dignity of being responsible in part for their own condition. What works is what you invest in those moral centers of excellence that are indigenous to those communities and enable the poor to participate in the private market. He refers even to a White economy. I do not know what a White economy is that he has identified in the report.

There is just one economy for which low-income African Americans and others can participate if they have the resources and the will. But certainly their condition is never determined by what White America does or liberal academics like Lynn Curtis decide is in their best interests.

Hugh Price: I think it is very clear that urban economics have undergone a profound change over the last 30 years and that the kinds of jobs that existed in factories that paid middle-class wages for marginally skilled people no longer exist. People in inner cities have gotten caught in the switches and their children are stranded in schools that do not function very well and do not equip them for a new economy.

That is where the pockets of severe poverty and despair exist. We need concerted action on the part of the public sector and private sector to address that.

I also think that there are some areas where people may not be able to function in the private economy and private labor market as we know it and if we want them to work we are going to have to take public action. There is a long tradition of public action to close those kinds of gaps even as the economy revives and the unemployment rates drop.

I think that the report is correct in pointing out those pockets that require concerted action. Additionally, urban children and rural children need to catch up with everybody else academically and get on the up economic escalator.

Commentator: Mr. Thurnstrom, what about that public action?

Steven Thurnstrom: First, let me say that I think it is just flatly wrong to maintain that the disintegration of the African American family and the high illegitimacy rate is a function of African American male unemployment. We have examined that theory very closely in the better part of a chapter in our book *America in African American and White* and I think we have demolished it.

Mr. Woodson points out quite correctly that the African American male unemployment rate during the Depression was several times higher than it is anywhere in the United States today and yet the African American family was not disintegrating. That theory simply does not hold up.

Commentator: In the few minutes we have left, what needs to be done?

Lynn Curtis: What needs to be done is not talk about liberal versus conservative but what does not work versus what works. What does not work is prison building, supply side economics, and other such policies. They have failed. What we need to do is stop doing what does not work and invest in what does.

What does work? Safe havens after school where children come for help with their homework works, as evaluated by Columbia University. The James Comer University School Development Plan where teachers and parents take over inner city schools works. The Ford Foundation's Quantum Opportunity Program that mentors high school students works. The community development corporations like the New Community Corporation in Newark that creates jobs works. The South Shore Bank, which creates banking for the inner city, works. Community-based policing by minority officers, works. Those are all proven and scientifically

evaluated programs and if we replicate what works at a scale that is equal to the dimensions of the problem, we can make an impact.

Robert Woodson: Let me just say in terms of remedies that I think they are moral centers of economic and social influence. One can see this in some of the major churches, such as Pastor Harold Ray's church in West Palm Beach, Buster Soares' church in Somerset, New Jersey, and Floyd Flake's church in Queens, New York, which is the fourth largest employer—840 people—because he is able to call people to take responsibility.

So I think there needs to be support. We need to give tax incentives for individual taxpayers to contribute directly to these institutions. We do not need another massive poverty program. This report is silent on the killing fields that are public schools, foster care, and all of the major systems funded out of the 5.3 trillion dollars over the last 30 years. There is no criticism of those institutions in this report and nor a word about those moral centers of influence that are rebuilding inner-city neighborhoods where government and everyone else has failed.

Hugh Price: First, I think we need mobilization to eliminate the achievement gap in our community and a lot of that responsibility rests in our community. That is why we at the National Urban League are partnering with the Congress of National African American Churches, and with the African American churches, fraternities, and sororities. We have got to spread the gospel that achievement matters and close that gap. However, we also have to sit on the public schools boards that have 93% of our children.

Second, there may be areas where the private labor market cannot quite reach because the skills are not there or the market opportunities are not there. There may have to be interim public action, just as community development corporations were supported by government and by foundations until the private sector caught up and just as the economic development administration in the South in the 1950s spent a lot of money on infrastructure and job creation in order to provide the groundwork for economic recovery in the South. I think we need to look at that.

Commentator: I have to interrupt you here. Thank you. Sorry Mr. Thurnstrom we cannot get to you. We will come back to this. We are out of time.

Steven Thurnstrom: Discrimination.

Commentator: Thank you all very much.

Curtis: That was the end of the debate. You can reach your own conclusions.

From our point of view, this illustrates a couple of things. First of all, in terms of our national policy, it illustrates that when you write a good national report it is not enough just to do that and distribute it to a few people or to let your publisher distribute it. You have to use the media. We obtained saturation coverage. Regardless of what you think of this report, we were on NBC, ABC, CBS, CNN, BBC, and the NewsHour with Lehrer and in almost every major newspaper in the country. Why? The reason is because we have as one of our trustees Leila McDowell, a cofounder of the only African American female-owned media company in Washington, DC. We worked with Leila and her colleagues through their network to get this kind of coverage. That makes an impact.

Second, this illustrated some of the techniques we are trying to teach nonprofit leaders in our television school. For example, I tried to repeat a couple of times the message that the rich are getting richer and the poor are getting poorer. They are all taught in media school to repeat their basic theme at least three times.

I tried to keep up a good offense and not be on the defense. For example, I made the ultimate

accusation to Bob Woodson by accusing him of taking federal grant money. This was in fact the case. When I was in the Carter administration I gave Bob a grant. How did he react? He was shocked and you saw some of his body language. This threw him off course a little. He had to think about that and that means he could not think about his next attack strategy. That is something, regardless of all the good research you have, that you have to do when you have only a few minutes on Jim Lehrer or on NBC.

I am suggesting that those of you who are researchers, practitioners, program people, policy makers—regardless of where you come from—need to pay more attention to media. You need to learn how to get the message out better. Certainly most of us were not trained that way. I know of no Ph.D. program in the country that requires you to go through media training before you get your degree. I suggest maybe most Ph.D. programs should have that requirement. For our part, the Eisenhower Foundation is trying to expand its television school and trying to educate progressive foundations to fund media in more ways.

To conclude with the big picture, one of the goals of the "communicating what works" movement is to educate the citizenry so that ultimately the citizenry elects officials who understand what works based on good research and who choose to appropriate the funds for what works. Another ultimate goal, one that is especially difficult but it needs to be focused on, is to try to help forge a political alliance among the truly disadvantaged, the working class, and the middle class to bring the rich back to the bargaining table.

I surely do not have the answers but we in this report have decided to try to go around the country to share these ideas with people and encourage you to work with us on this convergence of research, policy, and media.

Question: I have a question about the role that the Clinton administration has played. I see them as being very skilled at manipulating the media. I wonder whether they have sent out messages that support the points that you are making in your report?

Curtis: I do not think they have sent out messages directly, but overall their policy is much more consistent with what we are saying than was the policy in the 1980s. In terms of what does not work well, President Clinton is for prison building, but he is not championing it. He has changed enterprise zones to become empowerment zones and he is done it in a way that brings more targeting of grants. He has not pursued job training as is necessary. He has said that we ought to have more Head Start. He has embraced community policing. He has embraced safe havens. He has embraced programs like the Ford Foundation's Quantum Opportunities program. Maybe the main way he has let us down at least from the perspective of this report is on welfare reform because we think that work first, which is the essence of welfare reform, is simply not going to work. It did not work for JTPA out-of-school youth and we think the same thing is going to happen again. That is why we talk about the model of the Argus Community in the South Bronx as a "training first" model.

Question: Why do you think it has taken liberal politicians so long to realize the importance of learning the skills needed for using the media and why is there such a slow movement to gain those skills?

Curtis: I do not know. That is a big question. I know that the conservatives do not worry about researching facts. They just go right to the jugular. They create their media package and they just do it like the tobacco companies who reframed the message from the health of youth to big government. I think often that the people on the left come off as being "tweedy" people sinking back into their big easy chairs on television whereas the conservatives sit up straight and go at it.

Abbie Raikes: I spent three years working on Capitol Hill, and I found that the Democratic Policy Committee, which puts out a spin to staff and members of Congress, had some problems in the organization. After the election when the Democrats lost was a very discouraging time and there was a lot of rebuilding that needed to take place. It probably affected the ability of the Democrats to come together to deliver a very strong message and to teach the up-and-coming politicians how to communicate that message. I think that there was some conflict as to what that message really was.

Question: Do you think that has to do with not having enough funding?

A. Raikes: Not from my perspective. The organizations, like the Democratic Senatorial Campaign Committee for instance, always have less money than the Republicans and that is always going to be the case, at least as far as I can tell. It seemed as though the Republicans followed rank and file and were soldiers in an army and the Democrats were much looser and more inclusive of alternative points of view, but at the same time were less formed.

Curtis: The lack of resources can get pretty scary. The right wing controls the media and what can we do about that? This report says we do not have as much money but we have bigger numbers, if we could only organize. That is why we start talking about community-based organizations learning media skills, and keeping together. We also talk about how organized labor has to get back in the picture, both in terms of funding and in terms of carrying the message. However, I worry about the disparity in resources because the other side controls the seven conglomerates that control the media.

Comment: People who have the resources tend to be more conservative.

Question: Why do you think that individuals, such as Rupert Murdoch, who control the resources tend to be more conservative?

Curtis: I do not know. We are getting into rather existential philosophy here. Perhaps it is because they have been successful business people and have accumulated great money through the capitalist system and therefore have bought into the capitalist system.

John Fantuzzo: One of the things that frustrates me — and I am coming from an academic context—is that when you are talking about the media, you are creating binaries — this works and this does not work — in order to enter into the debate. However, as soon as you enter into the debate, and into those dichotomies, you distance yourself from the knowledge base because it is not knowing what works, it is knowing what is working. The academic community has to be much more responsible in articulating an understanding of urgent knowing because most of these situations are situations where we have to do something before we have an adequate knowledge base. The mandates that are driving us to do something are greater than the mandates to increase a knowledge base. We do not have substantial knowledge bases in some of these areas and to set them up as a model that works is dangerous because there is a lot of ammunition that can shoot that down. You have to articulate a research agenda that articulates prioritizing and scaffolding—a knowledge-building process that helps educate the foundations and the federal government. Instead of having the federal government and the foundations create programs driven by the need for an intervention, the intervention should be based on the quality of the knowledge we have through a scaffolding process. It is a process, because when you have people like Dreyfus and other institutes ask whether you have multiple solutions for multiple problems, the world is responding to this problem as multiples. It is a multivariate understanding. If we do not articulate a multivariate understanding then we decontextualize

these problems. As soon as we take the problems out of context, we make ourselves vulnerable to the antagonists. Academics have to articulate the notion of urgent knowing, that we are knowing in a context of very complex problems.

Think of how we address the AIDS problem. I saw the posters that said, "AIDS research equals life." This is a terrific ad because what they are saying is that we have a complex problem and we need to invest in a knowing process related to services. There are some good examples of how the medical community created an international enterprise to address the magnitude of the problem of AIDS and they communicated how we needed to put a lot of money into research and to take what we have gotten from the research and disseminate it. We need that kind of focus on complex social problems.

I get a little bit uncomfortable when I hear somebody say what works. It is almost like entering the legal adversarial environment of saying there is a competition for what works versus what does not work. We know that people who drive the agenda are not driven by what works, like the DARE program for children. There are so many programs that are being funded because they fit political mandates. When we say what works, we can present the evidence but that is not compelling enough to change the mindset. How do we communicate that we are in a context of urgent knowing, like the AIDS research? How do we generate that motivation so urgent knowing will give more resources to research and then connect research to service? I think that is where we have disconnects.

Curtis: You are really striking at the heart of the debate that needs to go on. I think the medical example is a really good one because essentially Americans accept the notion that if there is an illness, you have to test remedies in a scientific way. They understand that you have to try this out on a bunch of people and then there is a matched group that does not get it and then a comparison is made of the two. In the context of AIDS or cancer research, there is pretty good understanding by the average American of what an experimental design is and how it should be used to promote good policy. It does not work that way in the social area however.

Fantuzzo: There many people who have never seen a person with AIDS and many people do not even know about AIDS research. They know, however, that it is important because the medical community has created that notion that we urgently need to know about this and we urgently need to do something about this because it impacts you. So they have created the inevitable spin. With social problems, we are so confused about what our agenda is. Education is almost a joke because within the educational community it is a hydra. It is hard to find the focus to set an agenda. We are so confused about what the audience is supposed to support. There is no focused sense of urgency.

Comment: The difference between social policy versus exact science is that the exact science is more clear cut. It is so complex and multivariate. In social policy, it is difficult to say that something is right and that it is absolutely the direction you must go.

Curtis: I am not ready to give up on what works versus what does not work. In the case of DARE, a lot of us have been criticizing DARE and they are on the defensive now. We made some progress. Similarly, my best example is McGruff the crime dog. This project was evaluated and the evaluation showed McGruff did not work. It is still getting funded, but it is now being attacked. I think continual repetition of the need for scientific evaluation can make a difference over the long run.

I worry when you say this is a complicated issue and we have to build knowledge. That is how we lost to the conservatives. They said it is a simple issue and all that is needed is a reduction of taxes and there would be Utopia. I am searching for a happy medium. Can we not talk about how complicated the world is, but still say that the problems are not straightforward, and here

are the kinds of things that seem to be doing well and we should do more of them. I really think we need to discuss this because we have not talked about that.

Fantuzzo: I meant that the onus is on the academic community to articulate a clearer understanding of urgent knowing that does not sell out complexity, because the academic community has to attend to that complexity. The disconnect between the academic community and advocacy is that the academic community has to be an advocate with a forward message that communicates the value of urgent knowing to society without selling out the research.

Question: What is the difference between knowing and action?

Fantuzzo: One communicates an agenda. I will give you an example. We are facing this in Philadelphia with the Head Start programs that we are working with. We have developed a very simple statement about sensitive, responsive knowing. Sensitive is very simple—and we want to talk about that in research terms, such as the dependent variable and the independent variable. Sensitive has to be linked to assessment and measurement. People understand the word sensitive. The word sensitive is not a jargon academic term. Everybody wants to be more sensitive. The issue is that your responsiveness has to be related to your sensitivity. We want people to be responsive or sensitive. The notion is being able to respond to that which you are sensitive. That is an example of how we have been communicating to the mayor and the city officials regarding the support of some of the research agenda. How you can be sensitive and responsive? No one wants a policy or a program that is insensitive and unresponsive.

Curtis: Can you say that in a 7-second sound bite? I agree with you, but if you are on television, which is where most people get their news, you will typically only have seven seconds.

Fantuzzo: I agree with you that the fact of knowing means almost inaction in the sense that we do not know enough, so even though we will communicate what we know our result to be, we cannot do anything yet because we do not know enough. Urgent knowing means that you are knowing to do something, and that there is an urgency about it. So I think it is how we communicate the connection between knowing and doing.

Comment: Let me say what is effective in the Ohio legislature. We do long-term research in a fast-moving environment where they make decisions very quickly, sort of like working in Congress. One issue we have to address on a consistent basis is how to communicate our findings quickly and concisely so legislators can make decisions. One thing we continue to talk about is how we are different from academics. The issue is not only how we communicate but also how we use language. It is very difficult for me to understand and put what you said in layman's language. As Mr. Curtis said, if you are on the TV and you are trying to communicate this to somebody, they are going to be lost. They are going to get lost and read the simple message because that they can understand. Even when I sit here and listen to you—and I do not consider myself a layman—it is really difficult for me to understand your definitions and what you are saying.

Fantuzzo: That relates to the connection between the academic community and the advocacy community. For good reasons, people are not trained and socialized to speak to the masses because the whole notion of specialization is to know a lot about a little and to be able to communicate a lot about a little.

Curtis: I think all Ph.D.s in social sciences should be required to take a course in media and to deal with these issues and to struggle with them in their own careers. They need to be able to say

very briefly to the layperson what the issue is, what the outcome is, and what the policy should be. You mentioned that advocates do not necessarily know how to communicate. I agree. However, most of the nonprofit organizations that have successes in the grassroots cannot afford a media director. All the conservative organizations have a big time media director who is paid big money and assistants and a whole set of equipment to support them. One of the things we are trying to do is to get money to bring on media directors or at least one media director for every 10 nonprofits in Philadelphia.

Comment: I used to work with the Urban Institute and I knew a lot of people involved in policy in Washington on the conservative and liberal sides. We had a lot of the academic type of knowing what is working and this was being discussed for housing policy and what HUD should do. However, while we were doing the research, going through the census data, and writing gigantic reports that we felt very proudly about, my friend at the American Enterprise Institute was setting up a think tank program which is now aired on public television. Whose agenda is being addressed on this program? Theirs. They were not doing the research and writing the big reports, but they were getting their message out. When I am in Washington having discussions with people, whose message am I hearing more? It is the media message. I know our reports were sound and that our research was well based, but in order to get all that great thinking across, it would be wonderful if a couple of our more publicly comfortable researchers could get the message out.

Curtis: I could not agree more. In writing this report, a very well-known progressive researcher and I had a discussion and this person explained something to me. I was looking for a short explanation and he went on for about 40 minutes and then there were 23 footnotes to his explanation. He ended up by saying, "Well, I guess I should say it more clearly." He should because he has important stuff to say.

Comment: Communication is so vital, not only oral communication but also written communication. You talked about the thick reports and again that is something we deal with all the time. We try to make our reports as concise as possible while preventing distortion.

For example, you talked about Ph.D.s. We hired a Ph.D. who has been in a university environment for over 25 years. He really could not communicate or write like we write. He had to have five, six or seven qualifiers or adjectives before he came to the central point. It took him a year or two to get his writing to resemble ours and he is still not there. I think that is a prime example of some of the problems that the more liberal sides of the aisle tend to have in terms of communication. The other side—they do not care. They just report.

Fantuzzo: A good example is the National Head Start Association's new journal called the *NHSA Dialog: A Research to Practice Journal for the Early Intervention Field*. Faith Lamb-Parker is the editor. They are setting that journal up to create a dialogue, to be basically comprised of published articles but also to generate a dialogue. If the academic journals and research journals have that context where you have more commentary and more dialogue within the journal, it is going to put a demand on the academics to communicate their concepts clearly and concisely and in a debate format where they are held more accountable for their ideas. Therefore, I think this journal is going to be good for the Head Start community.

Curtis: From our perspective, we will be trying to create a "what works" web site that eventually would be used by people in the trenches. I do not know if we will ever get to that stage, but I would like to be able to have someone say, "I am going be on the local 6 o'clock news and we will be talking about mentoring. I wonder what are the best mentoring programs around the country," and then sit down and in 30 seconds come up with some good examples. This is from

a practitioner's point of view that is parallel to what I think you are saying from a scholarly point of view.

Question: I have a question on a different point, basically about social content of the Kerner Report and the update. Individuals tend to argue at the extremes. Republicans have their views and Democrats have their views and sometimes the truth is somewhere in the middle. With the Kerner Report and also relative to what Robert Woodson said, how much did the liberal perspective influence the update to the Kerner Report or perhaps even the original one and how much of what Robert Woodson said do you believe?

Curtis: I think the original Kerner Report was within the liberal tradition and our update certainly is. My co-author is former Senator Fred Harris who has run for president and is a good Oklahoma progressive. He is now writing novels too. It is in a liberal tradition. How much do I agree with Robert Woodson? Not very much. We are coming out with a second edition in the fall and we will have a whole chapter that criticizes the critiques. Much of what Woodson said was just not true. He said there were no centers of moral excellence. That is a big conservative theme. However, in the first video clip, you saw Father William Lindner. He is a priest who began the New Community Corporation, which is not only about jobs and economic development, but also about creating a center of moral influence in the central ward of Newark.

Woodson said none of our models were based on good science. We went out of our way to say that especially for the people programs rather than the economic development programs, we were basing our models on scientific research, such as the Quantum Opportunities program that was evaluated by Brandeis University. It has control group design. It was solid. A lot of what they say are outright lies, but people do not have the time to do the research to see that they are lies.

It is so easy to shoot holes in the conservative arguments and I think that is an important part of the national debate. We may have to be cautious about what works. Our arguments can be much stronger than some of this ideology that supply side economics works and prison building works.

New Foundation Initiatives

CHAIR: Lonnie Sherrod
PRESENTERS: Ruby Takanishi, Kathryn T. McLearn, John Sumansky, Susan Nall Bales, Lonnie Sherrod

Lonnie Sherrod: This session is entitled New Foundation Initiatives. The purpose is not to provide instructions on how to apply to the foundations represented here, but rather to give examples of the ways in which foundations work that has an impact on the world aside from the kinds of grants they make.

Around the turn of the century, there were many charities in this country that did good work providing food for people in homes and similar kinds of services. However, philanthropists who arose around that time, such as Carnegie, Ford, and Rockefeller, saw those charities as only treating symptoms of the problems or providing temporary relief. Instead, they wanted their new philanthropies to identify and address the core causes of social problems.

Although they did not fund many science projects, these philanthropists saw science with its ability to separate cause and effect as a means to help them identify the core causes of social problems. A number of foundations from this early period of philanthropy, particularly the Laura Spellman Rockefeller Foundation, were particularly important in establishing the field of child development research as we now know it today. Some people have characterized this period of philanthropy as one that attended to individual improvement, such as funding libraries and other programs that helped people to improve themselves.

Two or three decades ago, foundations began to be more concerned with social reform, systemic change, and community economic development and less concerned with the kind of philanthropic work that led to the establishment of the field of child development. This recent change in the focus on social reform has directed foundations' attention away from science, but that is another session in and of itself.

Foundations fund many interesting initiatives, and the purpose of this session is to describe some of what they do. We are pleased to have representatives from four important foundations with us today.

Ruby Takanishi: The Foundation for Child Development, a national privately endowed foundation, has an interesting history that is relevant to the connection between research and policy—an overarching theme of this conference.

In 1899, young daughters of investment bankers in New York City decided that there were children from low-income families in the city's tenements who were disabled, largely by polio and other diseases, and who were not able to benefit from public education. This concern led these young women to establish the Association for the Aid to Crippled Children, which was the name of the Foundation for Child Development until the early 1970s.

These women developed a model for the association as a public charity. Working with other settlement houses and charitable organizations, they successfully integrated poor, physically disabled children into not only the educational system but ultimately into the public education system in 10 years. Then they started to launch a visiting nurses service oriented toward providing a holistic family mental health approach to children, largely disabled by polio, in New York City.

Thus, until about 1944, we had a very long history as being a direct service charitable fundraising organization. Then, during the Depression, a very wealthy silk merchant named Milo Belding who liked the association's holistic approach to working with children and their families and made a major bequest that turned the Association into a private grantmaking philanthropy. That is a very brief history of who we are.

As a foundation, we have just approved a refined mission statement reaffirming our commit-

ment to helping all families, particularly families with low resources, to meet their children's developmental needs for optimal development. This includes high-quality child care and education, health care, food, decent housing, and income security for families. We also believe that family supports come from partnerships among government, families, nonprofit organizations, and the business sector. Our funding portfolio reflects this investment.

The 1996 welfare legislation highlighted the fact that many parents in the U.S. work, yet their families are still living in official poverty or in poverty because they do not have the resources to purchase basic necessities, such as adequate housing, food, health care, child care services, and education for their children. If the 1996 welfare legislation is successful, we would expect the number of working poor families and their children to increase in the coming years.

What has struck me about the emerging concern for the nation's forgotten families is that we do not know a lot about these families and what is happening to their children. About a year ago, we started to focus an important part of our grantmaking program on understanding who these families are, how many working poor families there are in the U.S., what their characteristics are in terms of family structure, race, and ethnicity, and what their needs are. Many of these families are recent immigrants.

We are interested particularly in what is happening to these families in the aftermath of the 1996 welfare legislation. We do this in a number of different ways. We support original research, as well as secondary analysis of particularly large national data sets. We are funding new surveys in New York City to measure the impact of welfare reform on children and families. Our research portfolio is, what I would call, multimethod and multidisciplinary. We are about to issue a bibliographic resource on books and papers, including a lot of the fugitive literature on the nation's working poor.

As a foundation, albeit a relatively small one, we support research, but historically we have been interested in connecting that research to policy analysis, advocacy, and leadership development. Moving from the generation of knowledge about working poor families, we have also decided to focus on two areas of policy and services: Early childhood education and care and child health.

In the early childhood education and care area, we are focusing largely on children from birth to age 5. Given my own experience with the Carnegie Council on Adolescent Development, we also have been doing a little bit on after-school care. However, because that is an area in which many other foundations are investing considerable resources, our efforts in after-school care will probably be limited.

I would like to share what we see as being the guiding principles of our grantmaking in the early childhood education and care area, which come from convening individuals in the field and having conversations with people who are knowledgeable in this area.

First, we are aiming for universal access. We believe that the current early childhood education and care system, which includes Head Start, is not only a very fragmented system but also a system in which access to different kinds of programs is based on income. There are large numbers of children, particularly the children of the working poor who have little or no access to these programs. If they do, their parents are paying very significant amounts of their income, anywhere from 20–40%, for these services.

Another guiding principle for grantmaking is that we are working toward high-quality early education programs and services that are licensed, regulated, and staffed by trained teachers who are well compensated and have benefits.

Our third operating or guiding principle is that we are working toward an affordable and accessible system to early childhood education and care using the federal guideline of not more than 10% of family income to be used for these purposes.

For example, we support economists who are exploring alternative mechanisms for financing this kind of early childhood education and care system that I have described. We support policy-related research, particularly experimentation by the states to improve quality through various

incentive systems. In New York State, we have been very active in trying to contribute to the implementation of the state's universal preschool education program, which is an entitlement for all 4-year-old children in the state, regardless of income, to have publicly financed preschool education. We have also been very concerned about issues of quality, good staffing, and curricula in these programs.

While we are a national foundation, these efforts, particularly the pre-K effort, focus on New York. We do see an increasing move toward these pre-K programs in other states, however, and clearly what happens in New York and in other states will be very important. We also have done some work looking at what the other 50 states are doing in this area and what the needs are.

In the area of child health, approximately 1 year ago the Foundation established the New York Forum for Child Health at the New York Academy of Medicine. It is an umbrella organization that includes state and city health and social service officials, child advocates, researchers, providers, and so forth, and focuses on the implementation of the State Child Health Insurance Program. However, in that particular effort and as part of conducting focus groups throughout the state, the Forum has gathered some very interesting information about what agency people, providers, and families see as barriers to participation. We hope some of those findings will lead to improvements in a more informed outreach effort.

In closing, one of the cross-cutting themes of our foundation is to build bridges between research and policy and between the research and policy community and the public. We also fund, in a somewhat smaller way, communications, including the work of the National Public Radio in covering children and youth issues.

Kathryn McLearn: I am from the Commonwealth Fund, which was one of the first foundations to become involved in child issues. The Fund was formed in 1918, and its first initiative involved rural and child health, setting up health clinics around the country in rural areas to focus on nutrition, cleanliness, and hygiene, because those were big health issues at that point in time.

In the early 1920s, we worked on child guidance and juvenile delinquency, two child and youth initiatives that took a physical health approach and then more of a developmental approach with young people. The Commonwealth Fund then left children's physical health initiatives for a while. However, with two current initiatives, the Healthy Steps Program and a new program that we are starting, we have come full circle to involve the health care system more explicitly in the developmental and behavioral aspects of child health, no longer focusing totally on the physical health of the child.

Healthy Steps is a national initiative sponsored by the American Academy of Pediatrics (AAP) and a partnership of the Commonwealth Fund and more than 50 funders from around the country. The goal of the Healthy Steps approach is to promote the physical, emotional, and intellectual development of young children from birth to age 3. We base our work on science. The intellectual footprint for this was both the Starting Points Report that brought together many scientific findings on early development and brain development and the research that we had about promising programs.

Also, as part of the Healthy Steps approach, we want to promote parents' knowledge, skills, and confidence in rearing young children. As we all know, parents are the people who most affect children in the early weeks, months, and years of life. We also want to expand pediatric practice and clinical capabilities to improve the effectiveness of pediatric primary care to meet the needs of families with young children.

Approximately 99–100% of children see a pediatrician within the first weeks or months of their life. By and large, most children have access to some sort of pediatric care. It is an opportune time. The pediatric community is well respected and there is no stigma attached to going to a pediatrician. In fact, young people with children want to be good parents.

Before we started this initiative, we did a telephone survey of 2,000 parents across the country

with children under age 3 to determine their needs, wants and concerns. It was a nationally representative sample. Some of the survey findings quickly gave us validation that we were on the right road with Healthy Steps. We found that early hospital discharge leaves parents on their own to cope with the task of rearing young children. Mothers are discharged from the hospital far too soon. One third of parents who left the hospital with their newborns after 1 day felt they could have stayed in the hospital a bit longer.

Even with all this hype about going home and receiving follow-up care and having access to home visitors, only 20% of mothers actually had access to home visiting or had a home visit within the first week of life. Only 44% of parents, less than half, felt confident about rearing their children and about being a new parent. Becoming parents is a huge change for these people, and they are very much alone.

We also found that the pediatric clinician is well placed to help mothers and parents with early aspects of child rearing. Regarding breastfeeding, we found that if a doctor or a nurse talked to a mother about breastfeeding she was much more likely to breastfeed. Additionally, we found parents are receptive to information about child rearing and wanted their doctor or nurse to talk with them about how to help their child learn, how to discipline, how to toilet train, sleep patterns, and what to do about things such as crying. We were surprised to find that parents were very interested in helping their children learn. They wanted them to be ready for school. We are not talking about numbers or reading necessarily, but how as parents they could prepare their children and how they could stimulate and nurture them.

We also found parents were not likely to read to their children very often. There is a tremendous effort underway to promote reading in the early years as a readiness tool and there is ample research to show that children whose parents read to them on a daily basis, do better in school. We found only 39% of parents read to their children on a daily basis. However, if the pediatric clinician talked to the parent about early learning, they were much more likely to read to the child. So again, there is a wonderful opportunity within the pediatric clinician's office.

We all know there is ample evidence to show the association between parental mental health and child rearing. When a parent is depressed or emotionally distant, they are less likely to parent well. Our survey also found that these parents are less likely to read, sing, have daily routines that we know are important, or play with their child. They are more likely to yell and be frustrated.

We wanted Healthy Steps to provide the expanded services one would find with many early intervention projects, certainly with Early Head Start and family support centers, family resource centers, and child development programs seen around the country.

Parents are also more satisfied with health providers who offer supportive services such as pediatric providers with home visits, a telephone advice line, information on newborn care, reminder systems, or a health record. These parents were much more likely to rate their pediatrician as providing excellent care, providing guidance, helping them to understand their child's growth, and really listening to their concerns. When we conducted the survey, we found that parents are eager for information and guidance and that health providers who offer it can really make a positive difference.

Thus, we began our Healthy Steps initiative, which has 24 sites nationally. Its basis was to provide timely information and parental support, to meet families where they are, and to foster strong relationships between children and their parents, between the parents and the health care provider, and among the members of the pediatric team. Healthy Steps is what we called enhanced primary care for young children. We monitor health and development. We promote health and optimum development. We also problem solve with the family.

The Healthy Steps program has seven components: (a) extended well-child office visits with the pediatrician or a nurse practitioner and our Healthy Steps specialist, (b) a series of home visits, (c) a child development information line that augments the medical emergency line, (d) parent groups, (e) child development assessments, (f) written information for parents that

emphasize prevention and health promotion, and (g) links to community resources.

Who is going to do this? This all sounds fine and it certainly coincides with the Bright Futures initiative and the AAP health supervision guidelines, but some pediatricians say:

> If I were going to do all this, I would be still doing the 4-month visit and the child would be 2 years old. I cannot get it all done. Managed care is telling me I have to see more patients. I'm getting reimbursed less from Medicaid to do these things that I know are important but I just cannot do them or I'm not as comfortable doing them.

In response to this we brought into the pediatric practices someone we call the Healthy Steps Specialist. He or she is a professional that has training or background in nursing, early education, social work, or early intervention. We did not want to create a new discipline but wanted to use the talents and experiences of these professionals to augment the pediatric practice. It was up to the practice to decide which individuals would fit best within the culture of their practice and the population they were serving.

The Healthy Steps Specialists had special training in child development. We also recognized they needed to have experience working with parents and feel confident working with parents because that is the medium to get to the children. It enabled the pediatric practice to focus on a whole-baby, whole-child approach to pediatric care. The specialists work with the pediatrician in the office and have longer visits with the parents to talk about early learning, the Reach Out and Read Program, the newborn's behavior and temperament, completing development assessments, and using what are called teachable moments to help the parents understand what is going on with their child—very similar to Brazelton's touchpoints. It is the same idea as using the infant and the infant's behavior to help parents understand development and to promote goodness of fit between the child and parent.

We use the Brazelton Neonatal Assessment Scale during the first home or office visit to help the parents understand and build strong relationships with their child. We do a series of home visits during the newborn period, the first 3 years of life, and then a series during the toddler period when there are fewer office visits and when parents are grappling with issues of autonomy, control, safety in the home, and those sorts of things. We also do them at the end of the 3-year initiative.

As mentioned, we have a child development information line where we get calls about behavioral issues and the day-to-day worries that mothers do not want to bother the doctor about. Mothers call the Healthy Steps Specialist a lot, and we have found the relationships to be very positive. One Healthy Steps family even wanted the Healthy Steps Specialist to be the child's godmother. Parents call the Healthy Steps Specialist to tell them their little boy took his first steps. Parents know they can tell the specialist anything about their child. Parents also reveal issues about themselves, such as depression. They do not feel as if they have to show off to the Healthy Steps Specialist. It is more of a conversation rather than checking in with the doctor.

This initiative has also been very helpful to the doctors. They have reported that they feel humbled by what they did not know and by what is reported back about the families; they feel this helps them practice a brand of pediatrics they know they should be providing. It also allows them to know that they are not dropping the ball when they find out a mother is depressed or there is something happening in the home, such as domestic violence. They know there is another team member—the Health Steps Specialist—who can follow up with the family or other services in the community that can be a resource.

Healthy Steps Specialists also run or facilitate monthly parent groups. We have even had some sites where the parents liked their groups so much that the groups became too large. In one Chicago group, the parents decided they wanted their own "play" group, so on the weeks that they were not at the pediatric office, they rotated and met in each others houses. Fathers are

coming to the office more, and many sites have group meetings in the evenings so that fathers who work can come with the mothers and their infants.

We do child development assessments as part of Healthy Steps not only to detect early delays and behavioral problems but to provide opportunities to discuss learning, coping styles, and parenting. We all recognize issues such as parental health and parental behavior affect child development. So the Healthy Steps Specialist and the pediatric practice are getting into areas they have not previously dealt with as much as they should have or might have liked, such as depression, smoking and second-hand smoke, substance abuse, family planning, and domestic violence. The Healthy Steps Specialists have been a great resource to new mothers, especially with early depression or depressive symptoms, feeling unable to cope, and anxiety over parenting.

We have a substantial amount of written material emphasizing preventive medical, developmental, and practical tips that would be applicable to child care centers and Early Head Start centers because they are not just medical issues. We have a health and development record that follows each child. It is like health passport and covers not just immunizations, height, and weight, but also contains behavioral, parenting, and safety tips and follows the child intensely from age 1 to 5. It also tracks the child's health, growth, and accidents up to age 18.

We also have another concept called the Links Letter. This letter is mailed out to parents 2 weeks ahead of the office visit to: (a) prepare parents to be active partners in the visit, (b) help them to know what to anticipate, (c) help them articulate any concerns, and (d) prepare them to talk about what their child is doing at this stage.

We have also linked pediatric practices to community resources. We have a parent-to-parent board and a community resource book about Early Head Start and Head Start programs in the community, as well as child care, WIC, and mental health services. The Healthy Steps Specialists can also make referrals.

We have 24 sites around the country. It is a universal approach. Our population ranges from low-income parents who receive Medicaid to upper- and middle-class parents. However,we probably have more low-income and Medicaid participants.

Our settings vary from managed care and large health systems to academic health centers, community health centers, group practices, and children's hospitals. We have 50 partners. Our investment is $18 million with local funders contributing $12 million. The national advisory committee includes Edward Zigler, T. Berry Brazelton, and David Lawrence, the CEO of the Kaiser Permanente Health Care System.

One of the other components of Healthy Steps is that the clinicians are trained. The training goals are to enhance clinicians' knowledge and help pediatric clinicians transform pediatric practices. We view this as a change in a system of care, feeling responsible for a group of families that no institution and system in our country has felt responsible for. It will be interesting to see if parents become the consumers whose demands lead to changes in pediatric care in the same way that mothers changed obstetrical care when they said they wanted more comprehensive care.

The training institute brings a team together to train the doctors for 3 days and the Healthy Steps Specialists for 5 days. The training is then followed up through ongoing technical assistance by way of biweekly telephone calls with the other Healthy Steps sites. Training is not a one-shot deal, especially with adult training and complex initiatives like this one. We know they need ongoing support from the beginning as they set up their office and computer or tackle the clinical challenges of working with a diverse group of families. Our support ranges from logistics to supervision.

I have presented a lot of information about the Healthy Steps program, but one thing I have not talked about is the evaluation of Healthy Steps being conducted by Johns Hopkins University. In this evaluation, we are looking at parent, child, and cost-effectiveness outcomes. The evaluation report will probably be available in 2001 or 2002.

We also are doing a lot of our own evaluation measures. We have talked with Early Head Start about their evaluation, and they are using similar measures. So we will have a large data set, probably one of the largest in the history of early childhood development. We thought our attrition rate would be 40%; it is 8%. Thus, our success brings a problem: It is going to cost us a lot more to do this evaluation than we thought if our attrition rate remains at its current level. It is often thought that people usually drop out during the first 6 months, but we are past the first 6 months. However, health care is volatile. People's insurance may change and they may have to leave the Healthy Steps Program. I know some parents have reported that they did not take a job unless they could keep the same insurance coverage because they did not want to lose their Healthy Steps Specialist. One mother was moving to Kansas City and wanted to know if she could get into the Chicago Healthy Steps site. There is a sense that parents enjoy this, benefit from it, and find it worthwhile.

Building on the Healthy Steps initiative, the other child health initiative the Commonwealth Fund is doing is focused on low-income families with young children. This is a ground-level initiative in 24 sites working to get the developmental services of the Healthy Steps approach into Medicaid and other systems that provide health care for children in low-income families.

Basically 53% of children under age 3 are living in families who earn less than $40,000 a year. That is a large percentage of American children. These families have trouble paying bills and often struggle to pay for the basics, such as formula, diapers, and clothing for their children. It is tough when you have young children. These families also have difficulty paying medical bills.

However, the good news from our survey is that one in four children is covered by Medicaid from birth to age 3. With the Medicaid expansions occurring around the country and the State Child Health Plus, we have an opportunity to provide more health services to uninsured children.

What was most striking to find in our survey was that 47% of all families in this country with children under age 3 had received some sort of government assistance since the birth of their child. We often think families go it alone, but in fact, they have had some helping hand—some sort of government assistance. We did not ask whether the assistance was local, state, or Federal, but it shows that there are avenues for government assistance.

We have started an initiative called development pediatric services where we will be working with state Medicaid directors, maternal and child health officials, and managed care to define the scope of benefits and to see if we can get the provision of developmental services that are important for young children written into the Medicaid contract. We also want to work with managed care and get these services included in their managed care capitation fee. We will be doing this over the next 5 years.

John Sumansky: First, I will tell you about corporate foundations in general, including the Toshiba America Foundation, which I represent. The second topic will be the new initiatives the foundation is taking in terms of its grant program by moving into the lower grade levels—kindergarten and up to grade 6. I will share some of the reasons why we are doing that and also share some of the conversations, ideas, concerns, and questions we have had when we decided that a shift to the lower grades as part of our giving program might be warranted at this time. I will also give you a glimpse of the inside thinking and types of discussions that take place before a foundation decides to somewhat shift its direction.

Let me begin by describing corporate foundations. First, when the word "foundation" is associated with a corporate entity, it could mean many different things. A corporate foundation can be completely independent from its corporate sponsor, in which case that foundation probably behaves more like the foundation where Lonnie Sherrod works than it does like a corporate entity. For example, the Ford Foundation is completely removed from any corporate interests, and it behaves like a private foundation.

There are other foundations that are completely dependent on their corporate sponsors, and they behave more like corporate givers than private foundations, which means that their gifts are much more likely to be tied directly to corporate interests. The size of their endowments is likely to be small, and their contributions to the foundation are likely to come from the corporation on an annual basis. Those contributions are called pass-through funds.

There are all also other corporate foundations that fall in between these two categories, such as the Toshiba America Foundation, which is a corporate-sponsored foundation. Legally, we are set up separately from the company as a 501(c)3 not-for-profit corporation. Our endowment is average for corporate foundations in the U.S., approximately $10 million. The difference in this kind of corporate foundation is that the board of directors consists of seven Japanese corporate presidents from the company. Thus, the kind of relationship I have to grantees and the kind of relationship extending from them to my board is completely different than what one might find in a foundation that was not related to a corporation. For someone looking for funds, these are important characteristics to be aware of. It makes a difference in how one approaches them, the kind of cases one makes, and the kind of behavior one can expect from someone like me compared to someone like Lonnie.

The corporate foundation must work hard to find a way to make its grant program benefit the company in some particular fashion. With a private corporate-sponsored foundation, the benefits that accrue to the company from the foundation's grant program are by law only allowed to be indirect. Any grant that I make from the Toshiba Foundation is not allowed, for example, in our case, to be used to purchase corporate products. That would be self-dealing. So when people write to me with a proposal in which they promise to buy 10 Toshiba laptop computers, they think it is a positive when, in fact, it is against the law for me to agree. So we do not do that. We are allowed only to encourage or at least appreciate it when our grantees hang our name up over the entrance to the New York Hall of Science, for example, for a program we may have funded. That is an indirect benefit, and the indirect benefits are important to corporate foundations. It is the direct benefits that are illegal.

Private noncorporate foundations usually reflect the interests and passions of their creators in their giving programs. For example, some wealthy individual interested in child development created a foundation, and, in turn, that foundation goes out and funds programs in child development. We are similar to private noncorporate foundations in the sense that the corporate entity that creates a corporate foundation also has an interest in the foundation working in areas of interest to the company.

In the case of the Toshiba Corporation, its interest, its future, and its profitability depend on science and technology and the ability to work in those areas. Consequently, the foundation funds programs in science and technology. The Toshiba Foundation was organized in 1990 as a private corporate foundation. As a foundation, we witnessed something very bad happening in seventh, eighth, and ninth grades, especially to girls and minority students, in terms of their abilities and their interest in the study of science and mathematics. Based on what we learned from research available at the time, we believed our grant program would be best aimed at those particular grades if our objective was to make a contribution to improvements in the teaching and learning of science and mathematics.

That brings me to this particular point in our history where we are now beginning to consider changing our grant program somewhat and shifting our grants, initiatives, and support to elementary school teachers in the teaching of science and mathematics. We are doing that for a number of reasons. One, strangely enough, and this may be contrary to what you may have heard about foundations and the competition for grants, we have experienced a decline in the number of proposals we receive from teachers and other educators requesting funds. This is for grades 7 through 12. We attribute that decline, which we have been tracking now for about 2 years, to three reasons.

The first reason is that America's return to preeminence in economic competitiveness has

lessened the pressure on the science education sector to perform miracles. Recall that it was only a few years ago that the blame for the lack of economic competitiveness was laid on education's doorstep, particularly in science and math. Now, since education has not been given credit for the restoration of U.S. economic competitiveness, calls for sweeping changes in science education are not nearly as strong as they were when the foundation was created.

A second reason is that strong economic conditions prevail throughout the U.S., unlike 4 or 5 years ago. These good times have lessened budgetary pressures locally, and many needed science and math items are now being purchased and integrated routinely into local school programs.

Finally, many schools, especially in science and technology, have realized they cannot bring their schools' technology needs up to where they need to be by doing it a year at a time. So we see many more school districts around the country going through the long tedious process of organizing bond issues, not for the purpose of buying another building or building more classrooms but for the purpose of buying computers and other scientific equipment and building science classrooms. So the overall demand for philanthropic dollars to fill the gaps has declined. The gaps are now being filled in other ways, and fewer and fewer teachers are applying for funds to improve science and math education.

As we have begun to think about moving our grant program into the lower grades, we have uncovered a number of concerns. First, we are concerned that there are no incentives or the incentives are not sufficiently strong enough among lower-grade teachers—in kindergarten, first, second, third, fourth and fifth grades—to prepare applications for funding. At least those incentives do not appear to be as strong, career- or promotion-wise, as they are in the upper grades.

Second, we have a concern about the absence of distinct subject matter curriculum orientation in the earlier grades. There are no science teachers teaching science in third grade; there are general third grade teachers. That is a concern to us.

Third, elementary teachers, in fact, overall may be less familiar with the grant process than upper-grade teachers. They work in elementary school buildings, where there simply may not be the kind of support that we have seen for the grant-writing process in some of the high schools, for example.

Another problem in funding at the lower grades is that K-6 teachers are likely to have had less formal training in science and mathematics than teachers in the upper grades. The question and concern for us is: How can they craft a project in science education without sufficient science background?

There is also the problem of continuing uncertainty about the role of computers in the classroom. More recently, we have been tracking the inroads that laptop computers are making, as more and more schools, in as low as the fourth or fifth grade, are pushing for all students to have his or her own laptop in the school.

We have evidence from other projects, namely a project we fund at the National Science Teachers Association each year. It involves a national competition for student teams under the direction of teachers in technology, who have a vision of the future of technology and have young people convey that vision. We have done this for the last 6 years and will continue to do so for 3 more years. About 33% of the nation's school population are enrolled in grades K–3, but only about 8% of the applications for this national competition, involving more than 20,000 students each year, come from grades K–3. So we have a very disproportionately small representation from elementary teachers in classes engaging students in these kinds of competitions, which are very popular and have high participation at the middle school and high school levels. At the elementary schools, however, we do not see much participation by the younger grade teachers in these kinds of activities, even for something that speaks very directly to the science, math, and technology standards.

What does this leave us with? It looks like we are going to try to target elementary schools anyway, but we are probably going to have to amend our proposal process. We will make the

proposal and the application process easier for elementary teachers in the hopes that maybe we can remove an obstacle to their participation. We will probably put strict upper limits on grants, perhaps a $2,000 maximum. We will probably carefully define what constitutes a science project in the elementary grades. This is where we could use a lot more research, especially on the corporate side because my corporate board members have a hard time figuring out how turning on a computer substitutes for science education, how feeling good about the environment is a substitute for science education, and how feeling good about things in general is a precondition to learning about something in particular.

There are lots of things going on in education that are disturbing to people who are not educators. We see mixed messages and confusion, especially in early childhood education, about what children can learn and what constitutes science education at elementary and kindergarten levels.

As grantmakers in this area—especially from the corporate side where we tend to be business people, not educators—we are much more concerned about getting good answers to questions. We are interested in helping and need you to tell us what your needs are. We search for answers all the time and we are happy to help. We would rather not invent solutions to the needs and problems of educators, especially at the lower grades.

Susan Nall Bales: I am glad to go last in some ways because I represent such an odd entity compared to the other foundations. We are not a grantmaking foundation; we are an operating foundation, which means we initiate programs. Our staff is devoted to solving problems or to exploring areas our board has determined to be important within our larger mission. The specific laboratory in which I work is children's issues, but the broader purview of the foundation is communications. That is the sole focus of the foundation.

Our foundation is also derived from a historical legacy, as you have heard from the other foundations as well. We are the philanthropic creation of Senator William Benton who at one time owned the Encyclopedia Britannica, which, too, was sort of a legend in its own time. Benton, along with Mortimer Adler, completely tore apart the Britannica at one point and reorganized it so it was not organized from A to Z, but around clusters of different ways of presenting knowledge.

Benton invented the first consumer research survey. He founded the Voice of America and a major advertising agency, Benton & Bowles. At one point, in his own run for the Senate seat in Connecticut, he invented most of the current frames of political advertising that we still see, including some of the more negative ones. The legacy that he started continues to imbue the way that we look at the foundation's mission. Our current Chairman Charles Benton, his son, said that his father spent the first half of his life basically inventing every commercial application of a communications medium. At one point, the Senator dominated the top three radio programs with programs that he had invented for his clients. He spent the next half of his life trying to undo everything that he had done in the first half and trying to figure out how he could make modern media responsive to public interest needs. Since he understood from the inside the way the media shaped public opinion, he wanted to know how he could begin to tease out the public interest application of communications.

That has been the legacy of our foundation. It is essentially looking at how communications can help people solve social problems: how people understand social problems because of the mediums that have been explained to them and how these mediums can be used to reframe their understanding and to help them solve problems.

I would like to talk about two areas in which we are currently working that seem relevant to the kind of work you all do. One is the development of messages that resonate with the public about children's issues and the other is the identification of messengers that can serve as effective disseminators of information. My essential point regarding both these issues is related to dissemination. Dissemination is not merely the direct distribution of research findings. The

way we all talk as expert elite about children's issues is not an effective way to speak about children's issues outside of this room.

To take up Lonnie Sherrod's earlier point, our foundation believes strongly that a little research and a little science need to get back into the equation of communications and that we really need to bring to the prospect of communications and dissemination the same kind of research and the evaluation we have brought to our policy and program activity.

I am going to describe two experiments where we are trying to do some of that. The first is in the area of early childhood education. Much of our work centers around the issue of framing, so I am going to give you a course in Framing 101.

What we know from the work of social scientists in a number of fields is that people understand just about everything by applying conceptual frames. Obviously, we cannot take in all of the information that bombards us. So we use different kinds of frames, different kinds of belief systems to organize information and to incorporate it into the way we live.

The media frames issues for us all the time in its organization of information and the kind of shorthand it uses to constructs a news segment. One example that most people recognize is that most election coverage uses a horse race frame—who is ahead or who is behind—or a two sides frame—this is what one side says and this is what the other side says.

It is very difficult to write outside of that frame. For example, in New Hampshire a couple of years ago, President Clinton and Speaker Gingrich sat down and agreed on issues. This was an impossible kind of news story to cover because one could not apply the traditional frames of coverage.

What is less obvious for people is that frames have serious implications for the way that we all try to do business in support of children's programs and services. Media scholar Charlotte Ryan has said it best when she says that every frame holds within it the notion of who made the problem and who gets to fix it. If a newscast presents a problem about children's issues as a problem that derives from a bad parent or from an ineffective parent, one cannot get a public solution into that equation because of the personalization.

When you look at the issue of child care and try to understand the media frames used to talk about it, one tends to find two dominant frames: the safety frame and the storage frame. The safety frame usually deals with unlicensed centers, children wandering into traffic, killer nannies, and child abuse. At a higher level, however, it also implies that child care is really about child storage, that it is about putting children on a shelf for some portion of a day and hoping that they are held harmless and then retrieving them at the end of the day. The dominant frame that appears on a daily basis in the local and national news makes it difficult to get into a discussion of quality child care, the educational aspects of child care, and issues that have arisen from brain research, a subject that has been so prominent recently.

The second frame is what we see in welfare reform coverage, that child care essentially exists to enable women to return to the work force or to enable a family to function. Again, this frame is not a child-centered frame. It is simply that the responsibility or the accountability in the frame is all toward whether child care actually facilitates that transmission and what happens to the child in that frame is not important to the coverage.

When a colleague of mine from the University of Washington and I looked at these kinds of coverage patterns, we decided we needed help in thinking about how to get outside of these frames so that child advocates, as they receive the next national Kids' Count Data Book or begin to work on the President's Initiatives on Child Care, could begin to talk in a much more expansive way with their own constituencies. We decided to ask social scientists for some alternative frames that had the possibility of opening up a different kind of discussion. In this case, we went to a pair of cognitive linguists, George Laycoff from the University of California at Berkeley and Joe Grady from George Mason. We asked them to look at the consequences of these two frames and if, as we suspected, the frames were extremely negative for promoting progressive public

policies around child care, to give us some alternative language and different kinds of metaphors that at least set up a different kind of conversation about child care.

First, they said not to call it day care or child care because those labels simply reinforce these dominant frames. The best ideas are to call it early education or early learning. In fact, calling it early education is very useful because education is quite salient right now as a public issue of concern. It is moving very quickly, catching up with crime as a topic high on the public agenda, and the challenge then is to expand the idea of education to younger ages which is something that seems doable.

Second, they advised us to talk about learning the basics. They include in the basics both those things we know happen to children in their early years and also those things that are part of the enormous concern Americans have right now about values. If you can fold the kind of effective learning that goes on in the early years—learning right from wrong, respecting others, and so forth—into the basics, this is something that will resonate with a public very concerned about children growing up valueless.

Third, they said to use well known homilies that help people understand the relationship of the early years to later development and that we have been too scientific in the way we have tried to describe what happens in children's early years. They gave us some easy metaphors to use. One is the shaping metaphor: As the twig is bent, so grows the tree. Another is a nutritional metaphor: The better the mind is nourished, the better it develops. They also gave a cultivation metaphor: Children are seedlings; they must be tended and cultivated at this early age. These metaphors become popular ways to remind people what they already understand in a different way and build government's role from analogies that are already acceptable to the public. They focused on the fact that just as we need government to set water safety standards and food and drug standards, we also need uniform high standards for child care and development. Water and food safety are issues that one can take into a focus group of extremely conservative Republicans, asking them whether the government should have a role in these issues. One will get absolutely uniform responses that these are places where the government has to have a role and that role has to be national. So, by analogy, by using this, one could build on the consensus that is already in place.

Finally, they said not to displace the parent. Promote parent education. Remember the quote that was read to us: A trained early education provider is not a substitute for a mother but may know some things that many mothers do not know, such as what kinds of explanations a 2-year-old child can or cannot understand.

We have tried to create something somewhat like a songbook. A tool advocates in the field can use as they think about how to translate their own program outcomes and the importance of children's services for a broad general public which is not always thinking about this set of issues. It is a way to conjure up a different kind of shorthand, a different kind of framing that has a better opportunity of succeeding.

We do this for a number of issues. We will be doing this looking at crime and violence prevention over the next month when we assemble a group of communications scholars, public opinion experts, and public health experts to look at what is happening with the overreliance in local news on crime coverage, its overrepresentation of people of color, and its overrepresentation of violent acts. The lack of context in that kind of coverage is creating, as we have seen from the number of different experiments, a notion that crime is essentially about race; it is becoming a code of how people look at the racial discussion. The only kind of response that one seems to be able to get is three strikes and you are out, a reliance upon criminal justice.

So we are going to look at whether there is a way of reframing violence coverage so that one gets a different understanding. For example, if one brought into the discussion where the perpetrator got the gun, whether the perpetrator and the victim knew each other, or some kind of sociological data such as where the perpetrator was employed, would one get a different understanding of what the social contributors are to violence? If one does not, is it better to sell

violence prevention programs apart from the notion of crime? Is it better to root them in education, for example, and leave crime by itself because one cannot get the solution unless the problem is understood in a different way?

This is the key area in which we do communications research, and we distribute our findings broadly. We routinely bring scholars together to communicate what we have found with people who are child advocates, by phone, by national teleconferencing, and in print publications.

The other area in which we are very active is in exploring the power of different messengers, both those that we cannot control, such as the media, and those that we can control, such as advertising and the Internet.

We have an enormous experiment on the Internet that I would encourage you all to take a look at. The URL is *www.kidscampaigns.org*. If we are doing our job right, what we have done will be invisible to you because this site is constructed as a way of applying what we have learned out of message development and framing it as our own captive communications vehicle.

We take the research that comes out of our other projects and try to apply it ourselves which is sobering in some respects. We have tried to make this an extremely subversive site. What we have found is that people who come to this site want to know something about their own child: how to get their child to sleep through the night or something related directly to their own parenting experience. A question like that cannot be answered on this site without finding out information about other children. So it constantly laces the collective responses with individual questions. It essentially is trying to set up a new social norm that we parent as a community and that one cannot parent by oneself without understanding the environment that is affecting other children and that his or her child is part of that group. That is done in very dramatic ways on this site. If one hits a section called Test Your Baby IQ which is our early education section, one will have questions that one asks as a parent oneself, but when one gets the answer to the question asked, information about other children is presented. It constantly gives readers not exactly the information they thought they wanted or needed to know.

We also try to cover very complicated issues in different ways. In that respect, it is sobering to find out exactly how hard it is to cover some issues apart from the dominant journalistic frames.

We just developed a huge section on children's mental health. What we found as we developed that particular section is that there are real reasons why the current journalistic coverage is so terrible. It is very hard to talk about promoting children's mental health in a community without immediately getting problem specific and trying to identify those problems and the solutions or what the clinical approach should be. The notion of promoting children's mental health before problems exist is extremely difficult, and it would be interesting to have your response on whether we have done it properly.

In order to do it, we brought in people from the Federal agencies that address children's mental health issues to give us a broad background, and then we brought in people who had actually started mental health programs in communities to jury it forth. Now we will be taking it to focus groups to ask people to look at the site to see if it effectively promotes children's mental health in their community, and what would be some of the indicators that they would take from the information.

We also found that in the current environment, people immediately want to talk about children's mental health and school safety. They want to talk about the incident in Jonesboro, Arkansas. There is the necessity of getting the issue away from that other issue which will only damage it, and that is very difficult. So in the set-up stories that we do for this, we talk about where our counselors are, how many counselors there are per school, and ways that people can use practical tools to look at whether their communities are doing enough to help children before they fail.

Another thing we found as we translated the issues from the way you and I talk about children's issues, to real people issues, is that we have to get rid of labeling. For example, parents who come to a site and want to think about how they discipline their child are not necessarily

going to look at child abuse; they are not necessarily going to ask whether they are abusing their child. So in a broadly based popular site, one needs to lace that information with information from other areas where they might look. For example, when looks for information on effective discipline, one would find indicators of what is effective discipline and what is ineffective discipline. Knowing that spanking is one of the key areas where Americans have not changed their practice or behavior, we very delicately laced the notion with help from the American Academy of Pediatrics on what we now know about spanking versus what we knew 50 years ago.

Finally, what we have found both in survey research, in focus groups, and in the work we are doing on the web site, is that people want to get connected as close to home as they can. If you ask people whom they believe as trusted messengers of information on children's issues, it is the local teachers. What we are doing now is taking this national encyclopedia and building it state by state, so people can find all the key resources for children in a particular state: all the key government agencies and how to get in contact with them, all the current children's campaigns, who is running an immunization campaign, who is running an early childhood education campaign, and so forth.

There is also a legislative update provided to us by a local partner. To do this we have established minigrants to 13 states to work with us. We have developed the template, but they essentially manage the care and feeding of these state sites. We will expand it to all 50 states within the next year so that people will be able to get information that is close to home. There will be chat areas that relate to each of the states so people can come in and talk about what is happening. We can get information to people where there are more trusted intermediaries.

In this area, as in all the work we do, we do intensive evaluations. We will be evaluating the way the site works in numerous ways that are useful far beyond this laboratory. We will be publishing this information and bringing people together to look at what has worked on our site, what we know about the way that people use the information, and how they travel through the site.

One of our questions has been can the public understand what is happening to children in their community? Will they then want to go over and look at what their opportunities are, not just as volunteers but as informed citizens, regarding the way that they relate to children's issues? So we have built into the site ongoing evaluations that will allow us to become more educated about what pulls people in and what they do once they are in our site. Then we will publish that information.

Sherrod: I am with the William T. Grant Foundation. You have heard about three kinds of foundations. The two omissions are family foundations that function much like corporate foundations with the exception that they are tied to a family rather than a corporation, and community foundations which function much like private independent foundations, except they reside in a community and typically serve the needs of just that community.

You have heard about what I think are some of the more interesting new initiatives that foundations are doing today. What I thought I would do is give one example of how foundations identify initiatives they want to pursue.

The Grant Foundation originated in the 1930s. Our whole program is focused on children and youth and research. Unlike most other foundations, we predominantly fund research. One of the areas in which we have been recently interested is violence prevention. I will go through these statistics quickly. The violent crime rate has increased dramatically. The incarceration rate has also increased dramatically. What this says to us is that incarceration is not a preventive for crime. While it may be a punishment for it, it does not prevent crime. If it had, then the violent crime rate would go down following an increase in incarceration. The United States stands out. Its incarceration rate is dramatically higher than any other industrialized country. Compared to countries such as Japan, the US is at the bottom with an incarceration rate 10 or 12 times higher. The reason for the increase in crime in the US is due to crimes committed by adolescents. This

indicates to us that youth is a target for crime prevention. If one wants to target youth, one gets them in school. So violence prevention programs in schools is one way to go.

Adolescence is a time when children experiment with many different behaviors, one of which is violent behavior. We now have a number of longitudinal studies that show that if one prevents damage to children during this period of experimentation and vulnerability, they usually land on their feet and turn out okay by the mid-20s or so. This was a point made by one of the Carnegie Council reports. It is a fairly well documented finding.

Children commit crime between school and the time before they go to bed. Therefore, one of the things that can be done is to give children other things to do, such as involve them in youth organizations, homework, after-school activities, and so on. That is one of the kinds of things that we are trying to do now.

Data from Dell Elliott shows the continuity rate. Crime decreases in one's early twenties, except for African American males where it does not decrease and continues until young adulthood. In looking at Elliott's data, one can see that the data for African American males who make a successful transition to adulthood—in terms of having a stable relationship and a reasonable job—resembles the data for female and White samples. This indicates to us that attending to the transition to adulthood and particular the school-to-work transition is one way of dealing with crime prevention. This is just an example of some of the kinds of data that we attend to in terms of identifying initiatives of where we want to put our money in research.

I know everybody needs money to do your work, but another way that you can interact with foundations is to share your priorities and help them establish their own priorities.

AUDIENCE COMMENTS AND QUESTIONS

Question: I am from Canada. What happens if a child is uninsured in America? Would the child go to a pediatrician, would they be part of Healthy Steps?

McLearn: In America, by and large, if the child had an acute problem, he or she would not be turned away from a hospital. For example, if the child had a broken bone or had been in an accident, they would be attended to. However, uninsured children do not have regular access to a doctor. Chronic conditions, such as asthma or ear infections, are not properly attended to. One might see an uninsured child in an emergency room late at night when the eardrum has ruptured and the child is in pain. So there would be very episodic and emergency room-driven care. They would not be part of Healthy Steps. This is a research project at this point and the child would have to be part of a system.

With the expansion of Medicaid, there are very few children under age 3 who do not have access to some sort of medical care. The biggest gap right now is in adolescent health care. We are finding some states want to invest more of the state Child Health Plus money into programs for adolescents. In some states, because of Medicaid expansion, they are reaching most of their young children, and adolescents are asking whether their parents could be included in the care because we find in America that children have access through Medicaid and government programs, but their parents do not because of the erosion of employer insurance. Some government programs are now planning to use some of this state Child Health Plus money to insure working parents. In Medicaid, mothers with children up to age 5 can get insurance, but not fathers.

There have been many other pediatric providers and foundations who have been interested in Healthy Steps. We are not going to do it the same way but would certainly be interested in providing you with our materials. Our colleagues in Boston are willing to provide training at a cost for people who want to do this, and we would perhaps provide somewhat of the infrastructure for you to begin to do it.

We felt that the local health foundation knows the people in their community who can make Healthy Steps work. As a national foundation, we do not do top down RFPs. We build partnerships because we know that this is the way to make it work. The community is invested at a local level and we on the national level eventually will leave.

Question: Would the Toshiba Foundation be interested in funding Head Start teachers in science programs?

Sumansky: I would think so, if things continue and we decide to fund lower grades. We will come up with a separate set of guidelines specifically for lower grade teachers and we would be happy to talk about pre-K as well as kindergarten. Teachers always have to weigh how to spend their valuable time. If it looks like the grant process is so formidable that it is going to take more time to do it than the money they would get, then they should not do it. To counter that, we have in our particular case tried to produce the easiest set of guidelines imaginable aimed specifically and designed with classroom teachers in mind. In addition to that, we are available—you can visit The Toshiba Foundation without an appointment. You can call us anytime. We spend as much time helping classroom teachers write proposals as we do managing the projects. In terms of final reports, the only thing that is required is a two- or three-page note telling us the extent to which you have reached the objectives you set out to accomplish. These are not grants that will choke a classroom teacher. We have many teachers who want to totally revise the curriculum singlehandedly and want $50,000 to do so. In our experience—over 7 years now—a classroom teacher cannot spend a lot of money. Our best grants have been those that have been on the order of around $3,500 per teacher for a classroom.

Larger school life projects receive funding closer to $9,500. When we see things larger than that, they typically do not work very well and we have money returned. The teachers bite off too much, especially in science. If they can do one small project that makes something a bit better for that class and future classes, that is fine. We are happy to work at that level.

Sherrod: Some years ago I decided I would refuse to ever again organize a session on how to apply to my foundation, and I still maintain that position. One word of advice, however. Whether one is a teacher looking for $2,000 or a researcher looking for half a million, the first important step is to examine the information from that foundation, the annual report or guidelines, or anything else. We get over 1,000 inquiries a year, at least a quarter of which should never have come to us if anyone had ever read anything about us.

POSTERS

Identifying Parent and Child Needs, Expectations, and Goals Regarding Cochlear Implants: A Focus on Effects

Susan Neufeld, Laurie Eisenberg

PRESENTER: Susan Neufeld

Cochlear implantation has been shown to be a viable option for young children experiencing profound hearing loss. Previous evaluations of the efficacy of cochlear implants (CIs) have focused on improvements in speech perception, speech production, and language skills. To date, few studies have explored the developmental outcomes associated with cochlear implants in children. Results from three studies are presented to allow for a rich exploration of the impact of cochlear implantation on child development.

In study one, subjects included 11 parents of children with CIs and a matched sample of 11 parents of children with hearing aids. In study two, subjects included 29 parents of children with CIs. Participants in both studies completed an interview questionnaire that addresses the behavioral and developmental impact of hearing devices on children. Responses were coded as relating to one of the following aspects of development: emotion, safety, communication, self-care, and social rules.

For study one, findings revealed no group differences in report of behavior problems due to hearing loss before receiving the device or report of improvement in behavior after receiving the device. Subsequent analyses revealed no group differences on report of problems before receiving the device or improvement after receiving the device.

For study two, which focused on within-group differences for the CI sample, results indicated parents reported significantly more problems associated with deafness prior to receiving the implant. Content analyses revealed that, for all age groups, parents reported cochlear implantation has the highest effect on emotion regulation and safety. This pattern held when analyzed by duration of implant.

Study three seeks to clarify the link of language to developmental domains by focusing on rule socialization of children. Specifically, children with CIs are compared to normal hearing children to elucidate whether compliance to rule systems follows normative trends. Subjects included 21 parents of preschool-aged children (2 to 8 years) with CIs. A normal hearing matched sample was derived from previously collected data. A questionnaire adapted from Gralinski and Kopp (1993) was used to assess child compliance to three parental rule systems: self-care, emotion competence, and safety.

Patterns in the third study revealed the expected developmental trend for the normal hearing sample, whereby compliance to safety rules is better than compliance to self-care or emotion regulation rules for all age groups. In contrast, while compliance to safety rules is better than compliance to self-care or emotion regulation rules for children implanted within a year, there is no clear pattern of improvement. For children using their implant more than one year, a pattern approaching normative development emerges.

Two major findings emerge from the data presented here. First, the findings from study one

suggest cochlear implants and hearing aids have a similar impact on numerous dimensions of child behavior. Second, previous research has shown that children with CIs demonstrate a neurophysiological lag consistent with time of implantation. The patterns of studies two and three indicate this lag may extend to other developmental domains, particularly to systems that rely on regulation and delay.

References

Gralinski, J. H., & Kopp, C. B. (1993). Everyday rules for behavior: Mothers' requests to young children. *Developmental Psychology, 29*, 573–584.

Comparison of the Types of Cooperative Problem-Solving Behaviors in Four Learning Centers: Computer, Dramatic Play, Block, and Manipulative

Genan T. Anderson

PRESENTER: Genan T. Anderson

This investigation utilized the naturally occurring behaviors and choice of learning centers by 4- and 5-year-old children videotaped without their knowledge. It examined the social interaction (defined as disruptive, unoccupied, teacher interaction—child initiated, teacher interaction—teacher initiated, onlooker, solitary, parallel, and cooperative) of children in four centers: block, dramatic play, manipulative, and computer. Two classrooms of children from a university preschool program made up the sample.

There were 42, predominantly White, middle-class children (20 boys and 22 girls) with a mean age of 56 months. Each center was videotaped for 30 minutes once a week for four weeks. Social behaviors of each child were coded in 10-second intervals for every 10 seconds the child was in the videotaped centers (*Kappa = 0.9*). The range of variation in parallel behavior was 17% with computers the high and blocks the low. When the computer center (high percentage in parallel play; low value in cooperative play) was compared to blocks (low value in parallel play; high value in cooperative play), there was a 19% difference in the amount of time spent in cooperative interaction. After the three hierarchy social behaviors (onlooker, parallel, and cooperative) were combined, there remained almost no difference between the centers although variations remained between gender.

We saw the area of greatest variation in magnitude in the interaction between gender and center most markedly in the computer center. While the ratio of time spent in each center is 3 minutes for boys to 4 minutes for girls for dramatic play, block, and manipulative centers, the ratio in the computer center is 5.3 minutes for boys to 2.2 minutes for girls. The more competitive nature of boys and the tendency of girls to be intimidated by the more dominant boys could explain the difference (Maccoby, 1990; Bergin, Ford, & Hess, 1993; King & Alloway, 1992). Maybe our careful attention to design of the center to control for gender equity failed (Petrakos & Howe, 1996). Perhaps the answer lies in the home socialization and the comparative differences in time spent with computers at home and at school for boys and girls—5 to 2 at school and 3 to 1 at home, boys high in both settings (Thouvenelle, Gorunda, & McDowell, 1994). Girls engaged in a higher percentage of cooperative play than boys in the computer center, dramatic play, and manipulative center. The highest overall percentage of time in computers was spent in parallel play. It may be that girls do not find the opportunity for complex social interactions in a computer center as readily as in the other three centers. It may be their prefer-

ence for interpersonal exchange draws them to the centers designed more naturally to facilitate these interactions (Petrakos & Howe, 1996; Maccoby, 1990). Does computer software favor the mathematical, cognitive thinker, over the more verbal, linguistic thinker? These are questions yet to be explored.

References

Bergin, D. A., Ford, M. E., & Hess, R. D. (1993). Patterns of motivation and social behavior associated with microcomputer use of young children. *Journal of Educational Psychology, 85*(3), 437–445.

King, J., & Alloway, N. (1992). Preschoolers' use of microcomputers and input devices. *Journal of Educational Computing Research 8*, 451–68.

Maccoby, E. E. (1990). Gender and Relationships: A developmental account. *American Psychologist, 45*(4), 513–520.

Petrakos, H., & Howe, N. (1996). The influence of the physical design of the dramatic play center on children's play. *Early Childhood Research Quarterly, 11*, 63–77.

Thouvenelle, S., Gorunda, M., & McDowell, C. (1994). Replicating inequities: Are we doing it again? In J. L. Wright, & D. D. Shade (Eds.), *Young children: Active learners in a technological age.* Washington, DC: National Association for the Education of Young Children, 151–166.

Cooperative Computer Use in Preschools: University-Head Start Collaborations

Mandy B. Medvin, Diana Reed, Debi Behr, Jan Minteer

PRESENTERS: Mandy Medvin, Elizabeth L. Spargo

Computers are relatively new to the preschool classroom. While there has been an explosion of developmentally appropriate software available for use by preschool teachers, research on curricular adaptations to effectively use such software in the classroom is limited. Indeed, there has been some concern that the use of computers is socially isolating (Elkind, 1996). In addition, the role of computers and their impact on low-income, rural populations has not been assessed. The purpose of this collaborative project between a college and Head Start program is threefold: (a) to develop educational approaches to facilitate social interactions via the computer by children in the preschool classroom, (b) to promote access to computer technology for low-income children in an underserved, rural area, and (c) to develop preschool teacher training workshops for Head Start staff to promote the developmentally appropriate use of computers. This report is a summary of our discussions thus far.

Our partnership extended out of an existing relationship from work on other community projects. A series of meetings were conducted at different points during the project between Head Start and Westminster College Preschool Laboratory staff. Our initial meeting established (a) common goals, (b) a listing of the advantages to both programs, (c) identification of an appropriate Head Start site, and (d) equipment and staff training requirements. Subsequent meetings included (a) training on the developmentally appropriate software selected, (b) a discussion of the techniques found to work best in the Preschool Lab setting, (c) adaptations necessary for the Head Start classroom, and (d) the nature of the computer workshop. Westminster College provided a computer and developmentally appropriate software to the Head Start site, as well as a student aide to oversee and facilitate children's interactions.

Our staff found that minimal adaptation was necessary for the Head Start classroom. Student aides pretested the children's basic level of computer skills at both sites. They introduced Millie's

Math House and then assisted children in working together on the computer. Children at the college site were more familiar with using computers. However, preschoolers at both sites were highly motivated to work on the computer, negotiated their use of computer time, and helped each other with the computer programs. We are currently analyzing in greater detail the nature of their social interactions and language use.

We are also in the planning phase for our computer workshop. While our workshop will be open to the community, one-third of the spaces will be reserved for Head Start staff. Head Start staff felt that the most valuable information for their teachers included (a) goals and objectives of the use of computers, (b) how to facilitate socially meaningful interactions among children, (c) specific words that teachers used to enhance facilitation, and (d) which techniques worked and which did not. Information that the college staff agreed would interest all attendees included the preparation of the classroom environment, how to choose good software, and ways to integrate computer facilitation into classroom curriculum. Both parties were interested in enhancing parental involvement.

References

Elkind, D. (1996 September). Young children and technology: A cautionary note. *Young Children*, 22–23.

The Impact of Technology on the Communication Development of Young Children Who Are Functionally Nonspeaking

Brenda Carlson, Karen Samels

PRESENTER: Brenda Carlson

This research was conducted to identify and understand factors that influence communication development of young children who are functionally nonspeaking, with a particular emphasis on studying the effects of using technology with this population.

Three years ago, the PACER Center in Minneapolis, Minnesota, received a grant from the Office of Special Education Programs to develop a model that would provide access to technology for children with special needs, technology training for their parents, teachers, and service providers, and technical assistance for those trainees. This project also produced a videotape on using technology with young children, a guidebook to help teachers integrate technology in their classrooms, and a training curriculum.

Initial research focused on the results of the team-building, training, and technical assistance for the adults in the program. Current research centers on the impact that access to technology has for young children from various cultures who have disabilities.

A barrier for several of the children in the project was language delay. It was hypothesized that use of various technologies built on the children's other strengths mitigated effects of the disability, and helped the children communicate more effectively. This study substantiated these hypotheses.

Some of the research questions posed were: (a) What factors positively affect communication development in young children with special needs? (b) How does access to and use of technology foster communication development? (c) What types of technology facilitate communication for young children who do not speak? (d) What factors positively correspond with technology use for the greatest impact?

Six children with communication delays were identified from among those whose parents

and teachers who had participated in training sessions that encouraged parent-teacher collaboration, integration of technology in early childhood education, and technology access for young children with special needs from various cultural backgrounds. These children were followed for 1 to 3 years to ascertain how technology influenced their communication development.

Data were collected by (a) preliminary videotape, (b) direct observation, (c) anecdotal records from parents and teachers, (d) a second videotape after the training, and (e) follow-up interviews with parents and teachers. Ongoing observation and videotape data provides longitudinal comparisons. The Language Sample of Expressive Utterances was used to measure communication by the children in videotaped observations.

Principles of qualitative research guided data analysis. Codes related to communication and influencing factors were developed.

Access to technology is a significant factor in the communication development of some of these children. Technology use supports communication, including oral language, vocabulary acquisition, and social interplay. Technology speaks for some of the children. Technology supports inclusion and self-esteem for children who are functionally nonspeaking. Team-building with parents, technology training, and technical assistance for teachers positively influence the use of technology for the child. Parental involvement, training, and technical assistance positively influence the use of technology for the child.

Classroom Environment

Structural Model of Head Start Classroom Quality

Martha S. Abbott-Shim, Richard G. Lambert, Frances A. McCarty

PRESENTER: Martha S. Abbott-Shim

The purpose of this research study was to develop, test, and validate a model that attempts to identify a) the characteristics and beliefs of Head Start teachers and teacher aides and b) the structural dimensions of classrooms that are associated with Head Start classroom quality. In preparation for building this structural model, five components of classroom quality as defined by the Assessment Profile for Early Childhood Programs: Research Version were analyzed to determine whether they hold together as a latent construct.

The Georgia State University Research Center on Head Start Quality is working in partnership with three Head Start programs in the southeast to address the influences on quality, and the impact of quality on children and families. The total sample size for both Years 1 and 2 was 190 classrooms across the programs.

The Assessment Profile was used to observe the quality of classroom teaching practices and includes five subscales: Learning Environment, Scheduling, Curriculum, Interacting, and Individualizing. The Teacher Beliefs Scale asks teachers to rate the degree to which they believe statements related to curriculum goals, teaching strategies, guidance of social-emotional development, language development and literacy, cognitive development, physical development, aesthetic development, motivation, and assessment. The Instructional Activities Scale describes classroom activities; teachers are asked to indicate the frequency of implementation for each activity in his or her classroom. The Family Involvement Survey asks teachers to report their beliefs about family-centered early childhood programming.

Data were collected in the winter of 1996 (Year 1) and in the fall of 1996 (Year 2). Data analyses were conducted using structural equation modeling with the Lisrell VII computer program. A two-stage approach was used to create the structural equations models. First, the measurement models for each latent construct were created independently. This was done to determine if the observed variables fit together as single latent constructs. For each of the measurement models, the goodness of fit statistics were .90 or higher. The structural models were then formed by estimating the strength of the path coefficients between the latent variables according to the proposed model.

The investigators tested the model with classroom level data from Year 1 of the project and validated the model with data from Year 2. The Educational Level of teachers and teacher aides (including CDA Credential) was shown to have a direct effect on Inappropriate Beliefs, which in turn impacted Inappropriate Instructional Activities. Inappropriate Instructional Activities then influenced the Quality of the classroom environment. Neither Educational Level nor Teacher Beliefs had direct effects on Quality, but did have indirect effects through Instructional Activities. Structure (class size and child/adult ratio) impacted Quality directly. Both Educational Level and Quality influenced Attitudes toward Head Start Families. All of the path coefficients were significant between latent variables and were replicated in very similar magnitude from Year 1 to Year 2 with the exception of the path from Quality to Attitudes toward Head Start Families. In Year 1, this path was not significant; however, in Year 2 it was significant.

Transitioning From a Half-Day to a Full-Day Early Childhood Program: Lessons From the Field

Lisa A. McCabe, Jayne Kemp, Moncrieff M. Cochran

PRESENTER: Lisa A. McCabe

In order to meet the needs of working parents, many Head Start programs may decide to transition from half-day to full-day early childhood programs. In this study, investigators examined the transition of one early childhood program using a case study approach. Document review, informal interviews, and semistructured interviews with eight teachers and three directors were used to examine the transition process from a half-day to: a) a combined half-day and full-day program, and b) an exclusively full-day program.

Many benefits were associated with becoming a full-day program. First, the full-day program meant children could stay in one place all day instead of making multiple transitions to different child care arrangements throughout the day. For teachers, benefits of the transition included increased salary, increased staff unity, and the chance to help develop a new program. Parents also benefitted by receiving access to a high-quality, full-day program that enabled them to work outside the home with less guilt and stress.

Transitioning also created many challenges. Teachers struggled to meet the needs of children in a full-day program in developmentally appropriate ways. This meant that teachers changed their teaching methods to, for example, provide more down time for children and to use the space designed for a half-day program in innovative ways. In addition, teachers avoided wrap-around care by staggering their schedules so that children could remain in one classroom with trained staff all day. Teachers also struggled to meet their own needs during the transition process. Regularly scheduled transition meetings provided teachers with an outlet to cope with their feelings of anger and sadness over the loss of the half-day program. Transition meetings also gave teachers enough time to plan the new full-day program. Another major challenge was to find a way to meet the needs of parents who wanted their children to remain for a second year in a half-day program. A lottery was held to determine which families would remain in the half-day program that operated within the full-day program for 1 year.

Based on their experiences, the staff of this program developed the following five suggestions for other programs making a similar transition. First, hold transition meetings in order to have enough time to plan and develop the new full-day program and to address feelings of anger and sadness about the transition. Second, expect change even after the transition. Because change is likely in the first year of a new program, transition meetings should continue even after the full-day program has begun. Third, consult someone with expertise in running full-day programs and someone with experience in leading groups dealing with emotional change. Fourth, have as much lead time as possible to give teachers and parents time to adjust to the idea of a new, full-day program. Finally, keep an open mind, communicate, and be flexible. Adhering to these ideas will make a difficult process easier.

Creating a Literacy Rich Environment in a Head Start Classroom: A Case Study

Kusum Singh, Susan B. Murphy, Andrew J. Stremmel, Janet H. Wilson, Lee George

PRESENTERS: Andrew J. Stremmel, Janet H. Wilson, Lee George

The present study examined and documented, using case study methodology, the process of creating a literacy-rich environment in one Head Start classroom. The theoretical ideas providing the framework for the study were: (a) a collaborative engagement in literacy curriculum development, (b) the use of multiple strategies in nurturing emergent literacy, and (c) the consideration of the social-cultural worlds of the children in designing literacy experiences. The case study method was used, allowing exploration of processes and dynamics of practice (Merriam, 1988). Data consisted of interviews of interviews, team meetings, field notes of classroom observations, and photographs. Data analyses followed the ethnographic guidelines of Erickson (1986) and Spradley (1980). Themes and categories were identified and expanded in a narrative format.

An important theoretical assumption underlying the study was that the engagement of a teacher in a collaborative effort to examine the literacy curriculum of the classroom would lead to the teacher's ownership of new ideas and development of a more conscious pedagogy around literacy issues. The findings of the study document the changes that occurred during the year. The weekly team meetings of the university and Head Start group became the vehicle for support and exploration of literacy-related ideas, providing a forum for discussion and sharing. The climate of openness and learning through dialectic interaction fostered the engagement and involvement of the teacher and her colleagues in experimenting with new ideas and creating a new level of enthusiasm and empowerment in the group. An intentional pedagogy emerged where teachers were mindful of the effect of the physical environment of the classroom on literacy activities, the role of dialectic learning for adults and children in all activities, and how to create an emerging curriculum following the interest and leads of the children. The case study considered the classroom from a systems perspective, where change in one part was likely to lead to changes in other parts of the system. The change process started with the empowerment of the teacher and led to three foci: redesign of the physical environment of the classroom, emergence of an intentional curriculum, and conscious consideration of the children's world. Examples of changes included more central display of books, integration of written language into all activities, and a new free flowing traffic pattern among activity areas. The result was to put literacy on center stage. In addition, a stronger intentionality in the literacy curriculum led to the selection of new books that honored diverse cultural backgrounds, books with rural, Appalachian themes and books depicting African American families. Finally, the teachers followed the leads and interests of the children developing ideas for literacy activities and projects. Conceptualizing the literacy curriculum as fluid, changing, and integrative allowed the written and spoken word to be the natural form. Many children responded with a keen interest in written language and displayed a vigorous love of storybooks.

We believe that the study has both theoretical and practical significance. The study developed a framework for linking theory and practice. Although many exemplary ideas for literacy development are found in research, implementation strategies for complex classroom environments have not been researched well. Hence, practitioners often continue to do what they have always done and do not experiment with new ideas. This research successfully incorporates innovative literacy ideas into classroom settings through teacher empowerment. Teacher ownership of new curricular ideas is an important condition for the successful implementation and institutionalization of exemplary practices.

References
Merriam, S. (1988). *Case study research in education.* San Francisco, CA: Jossey-Bass Inc.
Erickson, F. (1986). Qualitative methods in research on teaching. In M. C. Wittrock (Ed.), *Handbook of research on teaching* (3rd ed., 119-161). New York, NY: MacMillan.
Spradley, J. P. (1980). *Participant observation.* New York, NY: Rinehart & Winston.

A Descriptive Analysis of Head Start Administrators' and Teachers' Attitudes Toward Men as Early Childhood Teachers

Tony-Adams Aburime, Peggy Answorth, Gwendolyn Johnson

PRESENTERS: Tony-Adams Aburime, Peggy Answorth, Gwendolyn Johnson

The development of this study was based on the belief that the attitudes of program personnel toward men as teachers have important consequences for current broad initiatives aimed at increasing the presence of adult males in programs and specific programmatic efforts aimed at the recruitment and retention of male teachers.

Seven hundred administrators and classroom teachers, randomly selected from Region IV Head Start programs, were surveyed with a self-report questionnaire to assess their attitudes toward men as teachers in Head Start or similar programs relative to the following dimensions: (a) capability/suitability in working with children, (b) emotional stability, (c) commitment/interest in performance improvement, (d) interpersonal relations, (e) dependability, (f) health and vitality, (g) personal appearance, (h) capability in working with parents, (i) community relations capability, and (j) general professional traits. Attitudes toward males in the 10 domains were assessed with a total of 56 items in the form of statements of desired characteristics of early childhood teachers. Subjects were asked to indicate: (a) if the female is more likely than the male, (b) if the male is more likely that the female, or (c) if both genders (male and female) are equally likely to possess or display each of the 56 characteristics presented in the questionnaire.

Analysis of the data obtained from 482 respondents revealed that the majority of respondents believed that men and women were equally likely to possess the characteristics desired of an early childhood teacher. The average rate at which respondents reported this opinion ranged from 58% (on suitability/capability in working with children scale items) to 84% (on community relations scale items). The mean rate at which both genders were described as equally likely to possess the 56 characteristics was 70%.

The study also revealed some stereotyped perceptions, which were more in favor of the female. In all of the eight domains where a significant difference was found in the rates at which one gender was described as more likely than the other to possess desired characteristics, the female was rated higher. An average of 23% of respondents described the female as more likely than the male to have the 56 characteristics; in contrast, an average of 7% described the male as more likely. Administrators were significantly more likely than teachers to describe both genders as equally likely to possess the characteristics desired of an early childhood teacher, and teachers were significantly more likely than administrators to rate the female higher than the male. Extensive empirical evidence indicates that the 56 characteristics on which the female and the male were rated in this study are not exclusively male or female. The paper includes a discussion of the implications of the study's findings and recommendations for programmatic initiatives.

Cultural and Linguistic Diversity

Phonological Production in Spanish-Speaking Children: The State of the Art

Brian Goldstein, Aquiles Iglesias

PRESENTERS: Brian Goldstein, Aquiles Iglesias

It is estimated that phonological disorders (i.e., difficulty producing speech sounds) affect 10–15% of preschoolers (Matthews & Frattali, 1990). Given the present population of Latinos under the age of 5, approximately 300,000 of these children are at risk for developing phonological disorders. The provision of appropriate diagnostic and intervention services to Latino children with phonological disorders is more difficult because many of these children speak Spanish as their home language and service personnel are often unaware of normative data for Spanish-speaking children. In order to provide appropriate diagnostic and intervention services, speech-language pathologists, Head Start personnel (i.e., directors, teachers, coordinators), and families need to be aware of normative data on phonological development and disorders in Spanish-speaking children.

Data on the production of individual speech sounds suggest that normally developing Spanish-speaking children accurately produce most segments at a relatively early age (Maez, 1981). By the end of preschool, only a few sounds, /g/ "g," /f/ "f," /s/ "s," /ʃ/ "ñ," /ɾ/ "r," /r/ "rr," are *not* mastered, that is, produced accurately at least 90% of the time (e.g., Acevedo, 1993; De la Fuente, 1985). Studies examining the use of phonological processes indicate that Spanish-speaking children have suppressed (i.e., no longer productively use) the majority of phonological processes by the time they reach 3½ years of age (Goldstein & Iglesias, 1996a; Stepanof, 1990). Commonly occurring phonological processes (evidenced more than 10% of the time) in both normally developing children and children with phonological disorders are cluster reduction ("plato" → "pato"), liquid simplification ("martillo" → "madtillo"), and stopping ("sopa" → "topa") (Goldstein & Iglesias, 1996a, 1996b; Meza, 1983). Processes such as initial consonant deletion ("sopa" → "opa"), weak syllable deletion ("martillo" → "tillo"), and velar fronting ("boca" → "bota") may also be exhibited commonly in children with phonological disorders. Less commonly occurring processes exhibited by both groups of children include palatal fronting ("baño" → "bado") and final consonant deletion ("flor" → "flo"). Normally developing children and those with phonological disorders also exhibit "unusual" (rarely exhibited) phonological patterns including deaffrication ("mucho" → "musho"), backing ("bote" → "boke"), and denasalization ("nariz" → "dariz"). Some patterns, such as addition ("arbol" → "balbol") and palatalization ("sopa" → "shopa"), are witnessed in normally developing children but not in children with phonological disorders. Other patterns, however, are seen in children with phonological disorders but not in normally developing children: lisping ("sopa" → "thopa") and nasalization ("dos" → "nos").

The coming decades will see an increasing number of Spanish-speaking children enrolled in Head Start centers in the United States. Approximately 10% of these children will exhibit phonological disorders that need to be referred by Head Start personnel and families to speech-language pathologists for appropriate management. The assessment of and intervention for

phonological disorders in Spanish-speaking children will be aided by the knowledge of phonological patterns exhibited in normally developing Spanish-speaking children and those with phonological disorders. Profiles of phonological development and disorders in Spanish-speaking children will ensure appropriate referrals for and valid clinical management of phonological disorders in Spanish-speaking children in Head Start programs.

References

Acevedo, M.A. (1993). Development of Spanish consonants in preschool children. *Journal of Childhood Communication Disorders, 15*(2), 9–15.

De la Fuente, M.T. (1985). *The order of acquisition of Spanish consonant phonemes by monolingual Spanish speaking children between the ages of 2.0 and 6.5.* Unpublished doctoral dissertation, Georgetown University, Washington, DC.

Goldstein, B., & Iglesias, A. (1996a). Phonological patterns in normally developing Spanish-speaking 3- and 4-year-olds of Puerto Rican descent. *Language, Speech, and Hearing Services in the Schools, 27*(1), 82–90.

Goldstein, B., & Iglesias, A. (1996b). Phonological patterns in Puerto Rican Spanish-speaking children with phonological disorders. *Journal of Communication Disorders, 29*(5), 367–387.

Matthews, J., & Frattali, C. (1990). The professions of speech-language pathology and audiology. In G. Shames, E. Wiig, & W. Secord (Eds.), *Human communication disorders: An introduction* (4th edition, pp. 2–33). New York: Merrill.

Maez, L. (1981). *Spanish as a first language.* Unpublished doctoral dissertation, University of California, Santa Barbara.

Meza, P. (1983). *Phonological analysis of Spanish utterances of highly unintelligible Mexican-American children.* Unpublished master's thesis, San Diego State University, CA.

Stepanof, E.R. (1990). Procesos phonologicos de niños Puertorriqueños de 3 y 4 años evidenciado en la prueba APP-Spanish (Phonological processes evidenced on the APP-Spanish by 3- and 4-year-old Puerto Rican children). *Opphla, 8*(2),15–20.

Native American Children's Performance on the Preschool Language Scale-3

Edgarita Long

PRESENTER: Edgarita Long

For over two decades, there has been a need to develop appropriate speech-language assessment tools for use with individuals from minority cultures (Evard & Sabers, 1979). Yet standardized tests normed on the mainstream culture continue to be used with Native American children (Failing, Stice, & Inglebret, 1993). This study was designed to determine if the Preschool Language Scale-3 (PLS-3; Zimmerman, Steiner, & Pond, 1992) could validly assess the language development skills of English-speaking Native American Head Start children in Northeastern Oklahoma.

Sixty Native American children (30 boys and 30 girls), enrolled in the Cherokee Nation Head Start program (CNHS program) in Northeastern Oklahoma were assigned to three age groups: age 3 (n=20), age 4 (n=20), and age 5 (n=20). The PLS-3 was administered to children at the CNHS Program by the author and trained speech pathology students.

Statistical results revealed that the gender and overall PLS-3 means were lower for 5-year-old males (M=92.20) and females (M=88.40), while the 4-year-old females (M=110.20) had the highest scores. The means for 4-year-old males (M=98.50), 3-year-old males (M=95.40) and

females (M=102.60) fell between these two extremes. A one-sample t test revealed that these test scores were not significantly different from US population norms of 100 (t-crit = 2.00, t-obtained = -1.10). The sample standard deviation (S =14.910) was similar to normed populations (S = 15.0). A two-way ANOVA (Age x Gender) indicated no significant difference between gender (F[1,54] = 0.0, p=.95), but there was a main effect for age (F[2,54] = 5.38, p=.007).

Further analysis combined the data from the two gender groups and examined it by PLS-3 subtests (Auditory Comprehension and Expressive Communication). The 5-year-old group had lower PLS-3 scores than the 3- and 4-year-old children. A two-way ANOVA (Age x PLS-3 subtests) with repeated measures on the second factor indicated meaningful differences for Age (F[2,57]=5.318, p=.008) and Subtests (F[1,57]= 9.247, p=.004). Post hoc testing revealed that the observed differences were significant (p=.01) for the 4- and 5-year-olds with lower performance on the Expressive Communication Subtest.

To investigate this drop in performance by the 5-year-olds, a second experiment sampled Native American children in several integrated Head Start programs in Northeastern Oklahoma. Forty 5-year-old children, 20 Native American and 20 White, were compared on the PLS-3 to the 5-year-old CNHS children. Although results revealed no significant differences between the three groups, the CNHS children had lower subtest scores than the children in the integrated programs who had nearly identical scores. Expression scores were lower than comprehension scores for all three groups. All three groups scored lower than the 3-and 4-year-old CNHS children.

An investigation of the PLS-3 test construction revealed two significant problems. First, at ages 5 and 6, there are only four items per subtest while at all other yearly age ranges there are eight or more. In other words, if a 5-year-old child misses one item at his or her age level, his or her score decreases by 3 months. Second, two items (Expressive Communication items 41 and 42) are considered to be culturally biased. Use of the PLS-3 as the only means of language assessment of 5-year-old Native American children is not recommended.

References

Evard, B. L., & Sabers, D. L. (1979). Speech and language testing with distinct ethnic-racial groups: A survey of procedures for improving validity. *Journal of Speech and Hearing Disorders, 44*(3), 271–281.

Failing, A. M., Stick, K. K., & Inglebret, E. R. (1993, November) *Speech and language assessment practices used with Native Americans.* Poster presentation at the American Speech-Language-Hearing Association convention, Anaheim, CA.

Zimmerman, I. L., Steiner, V. G., & Pond, R. E. (1992). *Preschool Language Scale-3*. San Antonio, TX: The Psychological Corporation.

The Effects of Family Structure, Ethnicity, and SES on Family Process in Early Adolescence

Judith Baer

PRESENTER: Judith Baer

While there is an ample body of literature that investigates normative parent-adolescent relationships, particularly parent-adolescent conflict, little has been done to demonstrate how aspects of the family interact with ethnic and socioeconomic variables to influence developmental processes (McLoyd, 1991). Historically, research on minority adolescents and their families has utilized inferiority or deficit models (Cheatham & Stewart, 1990). At the same time,

the changing demographics of the US indicate that there are growing numbers of adolescents from diverse ethnic groups. Allison and Takei (1993) indicate a need for studies that examine parent-adolescent conflict by race and ethnicity. Prior studies of this type are sparse and have focused on older adolescents.

The purpose of the present study was to address this gap by examining how family structure and SES affect family conflict, communication, and cohesion in three ethnic groups of adolescents: African Americans (N = 1886), Mexican Americans (N = 2657) and European Americans (N = 3052). First, differences between sixth, seventh, and eighth graders on family conflict scores were examined. An increase in family conflict scores from sixth to eighth grade was predicted based on previous studies indicating an increase in family conflict during early adolescence. This tested the generalizability of findings from earlier studies to African American and Mexican American groups. Second, the influence of SES as a moderator of family conflict was examined for intact and single-parent families in each ethnic group. Although family conflict is considered normative to adolescent development, lack of resources may exacerbate conflict. It was predicted that single-parent families would have higher levels of conflict than intact families.

Results showed that family conflict increases significantly in early adolescence in all three ethnic groups extending earlier work showing similar patterns (Steinberg, 1990, 1989). For Mexican Americans, the mean changed from 2.4 at sixth grade to 2.8 at eighth grade (t = 4.7; df = 732, p<.000) For African Americans, the mean changed from 2.3 at sixth grade to 2.7 at eighth grade (t = 4.4, df = 683, p < .000) This generalizability is important because an escalation in conflict is integral to some theories of early adolescence. While the families did not differ on the basis of ethnicity, there were small but significant differences between single-parent families and intact families in all three groups such that single-parent families had significantly more conflict and less communication than intact families (family communication t = 3.7, p <.000; communication with mother t = 2.9, p<.000; family cohesion t = 3.5, p<.000).

Results of the regressions indicated that SES was not a significant predictor of family conflict. However, the mean differences between intact and single-parent families are in keeping with research on European Americans showing increased rates of diminished parenting associated with depression and stress in single-parent families (Forgatch, Patterson, & Skinner, 1988). Diminished and disruptive parenting is correlated with adolescent problem behavior. One of the prime stressors most often reported by single mothers is low income (Conger & Elder, 1994).

References

Allison, K. W., & Takei, Y. (1993). Diversity: The cultural contexts of adolescents and their families. In Richard M. Lerner (Ed.), *Early adolescence: Perspectives on research, policy, and intervention*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Cheatham, H. E., & Stewart, J. B. (1990). *Black families: Interdisciplinary perspectives*. New Brunswick, NJ: Transition.

Conger, R. D., & Elder, Jr., G. H. (1994). Families in troubled times. The Iowa Youth and Families Project. In R. Conger & G. H. Elder, Jr. (Eds.), *Families in troubled times. Adapting to change in rural America* (pp. 3-19). New York: Aldine De Gruyter.

Forgatch, M. S., Patterson, G. R., & Skinner, M. L. (1988). A mediational model for the effect of divorce on antisoical behavior in boys. In E. M. Hetherington & J. D. Aresteh (Eds.), *Impact of divorce, single parenting, and step-parenting on children* (pp. 135-154). Hillsdale, NJ: Lawrence Erlbaum Associates.

McLoyd, V. C. (1991). What is the study of African American children the study of? In R. Jones (Ed.), *Black psychology* (3rd ed., pp. 419-440). Berkeley, CA: Cobb & Henry.

Steinberg, L. (1990). Interdependence in the family. Autonomy, conflict and harmony in the parent adolescent relationship. In S. S. Feldman & G. L. Elliott (Eds.), *At the threshold. The developing adolescent* (pp. 255-276). Cambridge, MA: Harvard University Press.

Steinberg, L. (1989). Pubertal maturation and family relations. Evidence for the distancing hypothesis. In G. Adams, R. Montemayor, & T. Gullotta (Eds.), *Advances in adolescent development* (Vol. 1, pp. 71–92). Beverly Hill, CA: Sage.

Early School Performance of Hmong Children in Comparative Context

Edith M. Gozali-Lee, Daniel P. Mueller

PRESENTER: Edith M. Gozali-Lee

This study examined how Hmong refugee children performed in American schools. The academic performance and classroom behavior of Hmong first and second graders were compared to those of their classmates from other ethnic backgrounds. This study is part of the ongoing evaluation of the St. Paul Head Start-Public School Transition Demonstration Project. The St. Paul Head Start-Public School Transition Demonstration Project is 1 of 31 sites across the country participating in a federal demonstration project that aims to improve transition into public school and increase the school success of children from low-income families, especially of children who have attended Head Start. Six inner-city elementary schools in the St. Paul School District are participating in the longitudinal study. The schools were divided into demonstration and comparison clusters. Cohort I entered kindergarten in the 1992–1993 school year (n = 248 children) and Cohort II entered kindergarten in the 1993–1994 school year (n = 280 children). All children were from low-income families; half attended Head Start. Nearly half of the children (46-47%) in each cohort were Hmong, 26% were Caucasian, 12–13% are African American, and 14-16% were from other backgrounds (Latino, American Indian, and other Asian Americans). Nine out of ten Hmong children received English as a Second Language (ESL) services. Baseline assessments were conducted in the fall of the kindergarten year in each cohort, and subsequent assessments are conducted each spring. Children's academic achievements in reading and mathematical concepts were measured using the Woodcock-Johnson Tests of Achievement. Teachers rated each child's social skills using the Social Skills Rating System. Information regarding school attendance was obtained from school records each year. Family background characteristics and information on parent involvement in the child's education were obtained through interviews with a parent or a guardian of the child each spring. For Hmong families, all instruments included in the interview had been translated into the Hmong language and were administered by bilingual interviewers.

Reading achievement test results indicated that there were no differences in average scores between Hmong and other children. Hmong and other children started at very similar baseline reading scores upon entering kindergarten. Hmong children also progressed at about the same pace as other children. On the mathematics achievement test, Hmong children started kindergarten with significantly lower scores than other children. However, by the spring of the first grade they had "caught up" to their classmates.

Teachers rated Hmong children favorably, particularly with regard to classroom behavior. Teachers rated first- and second-grade Hmong children as more cooperative, having more self-control, and showing fewer problem behaviors. Also, Hmong students were absent less frequently than other students. Early school performance results suggest that Hmong children are able to perform at similar levels to other children from low-income families in reading and mathematics. Head Start attendance and Transition project participation may be partly responsible for their success.

Improvements in English and Spanish Language Expression and Comprehension of Latino Preschoolers

Valerie A. Malabonga, Mary-Lorraine Cox

PRESENTER: Valerie A. Malabonga

This study investigated the improvements in English and Spanish expression and comprehension of Spanish-speaking, Latino children attending a free preschool catering to a low-income Latino and African American community. The preschool emphasized the learning of English but supported the children's Spanish language skills by having Spanish-speaking teachers and providing Spanish curricula and materials. At the start of the school year, 20 Latino boys and 28 Latino girls were assessed. Of those children, 18 boys and 25 girls were assessed again at the end of the school year. For comparison purposes, African American children who spoke only English were assessed for their English comprehension and expression at the end of the school year. The comparison group included 16 boys and 15 girls.

To test children's oral expression, the PRE-LAS Let's Tell Stories subscale (Duncan & de Avila, 1986a, 1986b) was used. For the Latino children, one story was read in English and the other in Spanish. Only English stories were read to the African American children. Using the PRE-LAS pictures, the story was read to the child and a stuffed toy or a puppet similar to the story's main character was also shown. The child was told that the stuffed toy or puppet spoke only English (or Spanish) and that the child had to retell the story in the language the stuffed toy/puppet understood. Each child's story was rated on a 6-point scale by two bilingual raters.

To test the children's comprehension skills, an examiner read popular storybooks to one or two children at a time. For the Latino children, one story was read in English and one in Spanish, or vice versa, and the language sequence was counterbalanced. For the African American children, only English stories were read. The children were individually asked 10 multiple choice questions about each story.

There was significant improvement in the English expression scores of the Spanish-speaking children from Time 1 to Time 2 ($t(30) = -5.57$, $p < .0001$). Their average score at the beginning of the year was .66; at the end of the year, their average score was 1.66. By comparison, the African American children had an average score of 2.71 at the end of the year. The difference between the two groups was significant ($F(1,59) = 14.28$, $p < .0001$). Also, at Time 2, the English comprehension scores of the Latino children (M=6.21) were not significantly lower than those of the African American children (M =7.03; $F(1, 59) = .31$, $p > .10$).

This study has the following implications for the education of Spanish-speaking, Latino preschoolers: (a) preschools that emphasize Spanish-speaking children's learning of English and simultaneously support the children's Spanish language skills can achieve significant improvement in children's English oral expression skills within just one school year; and (b) even if they are not able to express themselves well in English, low-income Spanish-speaking children comprehend nearly as much English as do low-income, native-born, English-speakers.

References

Duncan, S. E., & de Avila, E. A. (1986a). *How to administer PRE-LAS English: Forms A and B* (2nd ed.). Monterey, CA: CTB/McGraw-Hill.

Duncan, S. E., & de Avila, E. A. (1986b). *Scoring and interpretation manual for PRE-LAS English: Forms A and B* (3rd ed.). Monterey, CA: CTB/McGraw-Hill.

Causal Explanations for Good and Poor Reading: Developments in Low-Income Families

Julia T. O'Sullivan

PRESENTERS: Janet Goosney, Julia T. O'Sullivan

Between 15–30% of school children have problems learning to read, and most of those children come from low-income families (Ellis & Large, 1987). Children from low-income families begin school at risk for underachievement in reading, fall farther behind in reading as they get older, and are at high risk for school failure, dropping out, illiteracy, and chronic unemployment in adulthood (Stanovich, 1986). Researchers believe that children's causal attributions about their reading influence their reading proficiency and that children's attributions are related to their parents' attributions (Miller, 1995). Although there is evidence to support these relationships in middle- and upper-income families, there are no published studies of attribution-achievement patterns in low-income homes. In this study, the objectives were to (a) measure causal attributions for reading in students from low-income families and to determine the relations between these attributions and the students' reading proficiency and (b) measure parents' causal attributions for their children's reading and relate them to the children's attributions about themselves.

A total of 513 students from Grades 3, 6, and 9 and one parent for each student (80% were mothers) participated. All participants were from very low-income families. The families lived in Newfoundland, Canada, the country's poorest province (Statistics Canada, 1988). Parents had an average of 9 years formal education. Most were unemployed fishermen/women or laborers in fish plants. Students' reading achievement was measured on the comprehension subtest of the Gates-MacGinitie Reading Test (MacGinitie, 1978). Students' causal attributions about their own reading and parents' attributions about their children's reading were measured on identical 14-item questionnaires. The independent contribution of seven causal variables (ability, effort, good teaching, liking reading, help at home, ease of reading material, and luck) to good and poor reading was measured on 7-point Likert scales.

The main findings were that as grade level increased, students focused more on themselves (e.g., their ability) and less on others (e.g., the teacher) as the causal determinants of their reading. High-achieving students emphasized their ability and liking for reading, while low achievers emphasized luck and other people as determinants of their good reading. Parents' attributions about their children's reading were very similar to the children's attributions about themselves. Students' attributions were related reliably to their reading achievement, accounting for 25–32% of the variance in the Gates-MacGinitie scores. Attributions to ability and liking reading were especially critical. Parents' attributions reliably predicted children's attributions.

These findings indicate that, in extremely poor families, children's beliefs about reading are tied to their parents' beliefs. Further, children who stress that their ability and liking for reading determine their achievement are likely to be the most proficient readers. These findings are consistent with those reported for children from more affluent homes. They support the recommendation that reading interventions should include a focus on both children's and their parents' attributional beliefs and should begin in preschool and the early school years before negative attribution-achievement patterns become firmly established and resistant to change.

References

Ellis, N., & Large, B. (1987). The development of reading: As you seek so shall you find. *British Journal of Psychology, 78*, 1–28.

MacGinitie, W. (1978). *Gates-MacGinitie Reading Tests.* Boston: Houghton Mifflin.

Miller, S. A. (1995). Parents' attributions for their children's behavior. *Child Development, 66*, 1557–1584.

Stanovich, K. (1986). Matthew effects in reading: Some consequences of individual differences in the

acquisition of literacy. *Reading Research Quarterly, 21*, 360–407.
Statistics Canada. (1988). *Population and dwelling characteristics—census divisions and subdivisions. Newfoundland: Part 2.* (Catalogue No. 94–102). Ottawa, Ontario: Author.

Social Class and Language Influences on Children's Understanding of False Belief

Ivelisse M. Martinez, Marilyn Shatz

PRESENTER: Ivelisse M. Martinez

Recent research in the area of theory of mind development suggests that social and linguistic variables may influence children's performance on false belief tasks. Moreover, during this period of development children engage in more talk with other, more knowledgeable interlocutors about causal relationships and mental states (Dunn, Brown, Slomkowski, Tesla, & Youngblade, 1991; Shatz, 1994). The specificity of the verb forms used to talk about mental states has some influence on false-belief task performance (Shatz, Martinez, Diesendruck, & Akar, 1995).

This study examined the effect of social class on children's performance in standard false belief tasks by testing children from high and low socioeconomic backgrounds from two small Midwestern cities and two cities in Puerto Rico. The participants were recruited from private preschools and Head Start centers. Assignment of the children to a social class group was determined by using the 1989 Socioeconomic Index of Occupational Prestige (Nakao & Treas, 1990) for head of household occupation.

Participants were 23 monolingual Spanish speakers, 12 from a low socioeconomic background and 11 from a high socioeconomic background, and 27 monolingual English speakers, 14 from a low socioeconomic background and 13 from a high socioeconomic background. All participants were given the four false belief tasks (two container tasks and two story tasks,) used in Shatz et al. (1995), by a native speaker of their language.

A score of 0–4 was computed for each child based on the number of correct responses to a think question in each task. A 2 (socioeconomic status [SES]: high and low) by 2 (language: Spanish and English) analysis of variance on the number of correct responses to the think question revealed a main effect of SES, $F(1,46)=88.426$, $p<.001$, a marginal effect of language, $F(1,46)=3.200$, $p=.08$, and no interaction. A one-way analysis of variance to test for the effect of language specificity on the number of correct responses to the think question in the high-SES group revealed a significant difference between the English and Spanish language groups,. $F=5.93$, $p<.05$.

The results of children's performance confirmed the hypothesis that socioeconomic background is an important variable to consider when testing children's understanding of false belief. The low SES Spanish- and English-speaking children's performances were both poor and did not differ significantly. Such poor performance in both groups may be due in part to a lack of opportunities to engage in talk that uses the forms available in either language to talk about inner states. This study suggests the possibility of intervention by the use of diverse language forms and types of interaction to help children attain the skills of understanding mental states that are useful for many forms of social understanding.

References

Dunn, J., Brown, J., Slomkowski, C., Tesla, C., & Youngblade, L. (1991). Young children's

understanding of other people's feelings and beliefs: Individual differences and their antecedents. *Child Development, 62,* 1352–1366.
Nakao, K., & Treas, J. (1990). Computing 1989 Occupational Prestige Scores. *General Social Survey Methodological Report, No. 70.*
Shatz, M. (1994). Theory of mind and the development of social-linguistic intelligence in early childhood. In C. Lewis & P. Mitchell (Eds.) *Children's early understanding of mind: Origins and development.* Hove: Erlbaum.
Shatz, M., Martinez, I., Diesendruck, G., & Akar, D. (1995, March). *The influence of language on children's understanding of other people's minds.* Paper presented at the Twenty-seventh Biennial Meeting of the Society for Research in Child Development, Indianapolis, IN.

Bilingual Education in the Public School Careers of Head Start Graduates

Sandra Barrueco, Norman F. Watt

PRESENTERS: Sandra Barrueco, Norman F. Watt

While outcome studies of Head Start have focused on the program's possible differential effect on distinct ethnic groups, few have addressed the outcomes of subgroups within these ethnic groups. A particular subgroup that warrants individualized attention consists of Latino children who are limited in their English Proficiency (LEP). The present study aimed to assess the degree to which Head Start may influence the communicative English language development and academic development of this important set of students.

The data for this study were extracted from public school records in a large metropolitan school district for three consecutive academic years (1994–1995, 1995–1996, and 1996–1997) to meet the following characteristics: (a) the children spoke primarily Spanish or (b) their families spoke primarily Spanish. Out of a universal sample of 13,852 students, 1817 were Head Start graduates and 12,035 had not participated in Head Start.

A one-way ANOVA revealed a statistically significant difference in the median income of the neighborhood where students resided between Head Start graduates and students who had not participated in Head Start (M_{HS}= \$17,836; $M_{non\text{-}HS}$= \$19,560, $F = 75.55$, $p < .001$).

Results of this study indicate that participating in Head Start positively influences one important developmental domain of public school students of Spanish-speaking families: communicative English proficiency, as assessed by the Language Assessment Scales (LAS) in English (DeAvila & Duncan, 1990). The degree to which participating in Head Start affects English mastery was not negligible; Head Start graduates are less likely to necessitate specialized LEP instruction when entering the school system in the first grade, even when socioeconomic differences were not accounted for ($0^2 = 26.12$, $df = 1$, $p < .001$). This chi-square value increased when SES differences where covaried. In addition, first and second grade Head Start graduates evidence greater communicative English proficiency on the LAS than their counterparts who had not participated in Head Start when covarying SES ($F = 7.75$, $p<.001$). While this initial superiority was found to dissipate after the first year, it is important to regard that Head Start graduates are less likely to be categorized as limited in English proficiency by the LAS when embarking on their school careers.

As tested on the Language Arts, Reading, and Mathematics subtests of Iowa Test of Basic Skills (ITBS), Head Start was not revealed to influence the academic achievement scores of first, second, or third graders from Spanish-speaking homes when covarying median neighborhood income.

One limitation of the present study is the inclusion of children who had participated in state-funded or private early childhood education (ECE) programs in the non-Head Start comparison group. To evaluate the contribution of Head Start in a more precise manner, future aims of this project are to describe and compare the linguistic and academic progress of Spanish-speaking students in Head Start, state ECE programs, private preschool, and no preschool. In addition, future investigations aim to examine the maintenance and development of the Spanish language.

References

DeAvila, E. A., & Duncan, S. E. (1990). *Language Assessment Scales.* Monterey, CA: CTB.

The Relation Between Multiple Classification Skill and Children's Early Skilled Reading: Implications for Reading Instruction and Intervention

Kelly B. Cartwright

PRESENTER: Kelly B. Cartwright

One task that has been shown to indicate an individual's ability to consider multiple aspects of a stimulus simultaneously is the multiple classification task, which requires individuals to classify items along two dimensions (e.g., by type and color) simultaneously (Bigler & Liben, 1992, 1993; Inhelder & Piaget, 1970). Because it appears that skillful reading depends on the ability to coordinate phonological and semantic information, it seems likely that children's ability to simultaneously classify printed stimuli on both semantic and phonological dimensions should indicate their skill at considering these kinds of information concurrently and correlate highly with children's reading skill.

Two studies investigated the role of multiple classification skill in children's reading. Forty-four 7- to 11-year-old children completed subtests of the Woodcock Reading Mastery Test (WRMT), Form G to assess decoding and reading comprehension ability, and the Kaufman Brief Intelligence Test to assess verbal and nonverbal ability. Additionally, children completed a domain-general multiple classification (GMC) task (i.e., they sorted objects by color and type simultaneously) and a reading-related multiple classification (RMC) task (i.e., they sorted printed words by initial phoneme and semantic category simultaneously). Correlational analyses indicated a significant positive relationship between children's RMC skill and reading comprehension, $r = .65$, $p < .001$. Furthermore, in a stepwise regression analysis that also included verbal ability and GMC skill, only RMC skill and decoding ability emerged as significant predictors of reading comprehension. A partial correlation revealed that RMC skill made an independent and significant contribution to reading comprehension over the contribution made by decoding ability, $pr = .44$, $p < .01$. A second study was conducted to determine the effects of multiple classification training on reading skill. Thirty-six children who participated in the first study were randomly assigned to three groups: 12 received RMC training, 12 received GMC training, and 12 (control) played Dominos with the experimenter. After five days of training, children were posttested on decoding and reading comprehension using the WRMT, Form H. Children who received RMC training showed significant improvements in reading comprehension at posttest.

These studies suggest that children's ability to simultaneously utilize semantic and phonological information, as measured by an RMC task, makes an independent contribution to reading comprehension. Because training in RMC led to increases in reading comprehension,

such training may prove to be a valuable means of intervention for the early remediation of reading difficulties by providing children with a skill that is important for successful reading. Additionally, this task might be adapted for use with prereaders by having children sort picture stimuli along semantic and phonological dimensions simultaneously in order to train them to utilize these types of information concurrently.

References

Bigler, R. S., & Liben, L. S. (1992). Cognitive mechanisms in children's gender stereotyping: Theoretical and educational implications of a cognitive-based intervention. *Child Development, 63,* 1351–1363.

Bigler, R. S., & Liben, L. S. (1993). A cognitive-developmental approach to racial stereotyping and reconstructive memory in Euro-American children. *Child Development, 64,* 1507–1518.

Inhelder, B., & Piaget, J. (1970). *The early growth of logic in the child.* (E. A. Lunzer & D. Papert, Trans.), New York: Humanities Press.

McCutchen, D., & Crain-Thoreson, C. (1994). Phonemic processes in children's reading comprehension. *Journal of Experimental Child Psychology, 58,* 69–87.

Curriculum Development

Long-Term Impact of a Verbal Interaction Program for At-Risk Toddlers: An Exploratory Study of High School Outcomes in a Replication of the Mother-Child Home Program

Phyllis Levenstein, Susan Levenstein, James A. Shiminski, Judith E. Stolzberg

PRESENTERS: Phyllis Levenstein, Sarah E. Walzer

High school graduation is an ultimate aim of cognitive programs for low-SES preschoolers at risk for educational disadvantage. That outcome is a goal of the home-based Mother-Child Home Program (MCHP), now the Parent-Child Home Program. This retrospective study, unusual for home-based programs, measured achievement of that goal in an authentic replication in Pittsfield, Massachusetts. The MCHP began in 1965, based on a theoretical/empirical foundation drawn from the fields of anthropology/linguistics, philosophy, psychology, and sociology. Most prominent were the writings of Bruner, Olver, and Greenfield (1966), Caldwell (1967), Hunt (1961), Sigel (1971), and Vygotsky (1962). The program was later endorsed by federal agencies and in reviews by Bronfenbrenner (1974), Hunt (1975), and others.

The MCHP's method is to aid low-SES parents (usually mothers) to be facilitators for embedding conceptual verbal interaction into their toddlers' early experience (Hart & Risley, 1992). It fosters this interaction through home visitors' demonstration of ludic verbal interaction techniques for parents to use with their children around program gifts of toys and books. Cognitive and academic successes of original MCHP children through 7th grade and for the Pittsfield replication through 8th grade (Consortium for Longitudinal Studies, 1983; DeVito & Karon, 1984; Madden, Levenstein, & Levenstein, 1976) seemed predictive of high school graduation.

The graduation and dropout rates of 123 young adults, available from the 209 who had been in five yearly cohorts of low-SES at-risk toddlers from 1976 through 1980 and were eligible on low SES criteria for the Mother-Child Home Program (21 randomized for a control group), were studied 16 to 20 years later. Group differences were compared via chi-square tests for categorical variables and the t test for continuous variables, using Statview statistical software for Apple Macintosh. Multivariate analyses (multiple logistic regression) were performed using SPSS for Windows. All p values were two-tailed. On an intention-to-treat basis, 76.9% of all subjects who enrolled in the program and 53.9% of controls graduated from high school, a marked numerical difference but not statistically significant because of the control group's small size ($n = 15$, $p = 0.07$). However, with adjustment for baseline IQ scores, the advantage of program subjects persisted (multivariate Odds Ratio 2.12, $p = 0.28$).

Subjects who had completed the full 2-year program replication as toddlers (65% of program participants) were significantly less likely than randomized controls to drop out of school (15.7% vs. 40.0%, $p = 0.03$) and more likely to have graduated (84.1% vs. 53.9% , $p = 0.01$). The dropout rate of program enrollees was lower than the national dropout rate of 27.4% for low-SES students, while program completers matched the national graduation rate for middle-SES students (83%) and surpassed that for low-SES students (64%).

The results of this study (deemed exploratory because of the small size of the control group

and the unavailability of some demographic data) (a) suggest that the high school graduation of low-SES students may be achieved by their enrollment in the Mother-Child Home Program, (b) indicate the exportability of this program, and (c) justify further controlled long-term studies of the program.

References

Bronfenbrenner, U. (1974). *Is early intervention effective? A report on longitudinal evaluations of preschool programs (Vol. II)*. U.S.DHEW, OHD 74-25.Washington, DC: Government Printing Office.

Bruner, J. S., Olver, R., & Greenfield, P. (1966). *Studies in cognitive growth.* New York: John Wiley & Sons.

Consortium for Longitudinal Studies. (1983). *As the twig is bent.* Hillsdale, New Jersey: Lawrence Erlbaum Associates.

DeVito, P. J. & Karon, J. P. (1984). *Final report, Parent-Child Home Program, Chapter 1, ECIA,* Pittsfield Public Schools.

Hart, B. & Risley, T. R. (1992). American parenting of language-learning children: Persisting differences in family-child interactions observed in natural home environments. *Developmental Psychology, 28,* 1096-1105.

Hunt, J. McV. (1961). *Intelligence and experience.* New York: Ronald Press.

Hunt, J. McV. (1975). Reflections on a decade of early education. In D.A. Wilkerson (Ed.), *Educating children of the poor, 1975-1985.* Westport, CT: Mediax, Inc.

Madden, J., Levenstein, P., & Levenstein, S. (1976). Longitudinal IQ outcomes of the Mother-Child Home Program. *Child Development, 47,* 1015-1025.

Sigel, I. E. (1971). Language of the disadvantaged: The distancing hypothesis. In C. S. Lavatelli (Ed.), *Language training in early childhood education.* Urbana: University of Illinois Press.

Vygotsky, L. S. (1962) *Thought and language.* Boston: Massachusetts Institute of Technology.

Violence Prevention in Early Childhood: Implementing the Second Step Curriculum in Head Start and Child Care Classrooms

Lisa A. McCabe, Moncrieff M. Cochran

PRESENTER: Lisa A. McCabe

The problem of youth violence begins long before the start of the teen years. Aggression in the elementary years is predictive of later aggressive and antisocial behavior (Huesmann, Eron, Lefkowitz & Walder, 1984; Tolan, Guerra & Kendall, 1995). Similarly, without intervention, aggressive children are more likely to graduate to more serious antisocial behaviors as adolescents (Tolan, et al., 1995).

Because the roots of violent behavior are found in younger age groups, prevention must start early. Second Step, created by the Committee For Children, is a violence prevention curriculum developed to teach social skills to preschool children. Photograph cards, puppets, and music are used to promote children's understanding of emotions and teach children how to interact effectively with peers. This study investigates the effectiveness of Second Step in reducing aggressive behaviors in child care and Head Start classrooms.

Four sites, two child care and two Head Start, agreed to participate in a pre and postcurriculum comparison. At each site, one classroom was randomly assigned to try Second Step and a second served as a control. Seventy-six children, 48% male and 59% White, were observed in their classrooms: Teachers filled out the Preschool Behavior Questionnaire (PBQ; Behar & Stringfield, 1974) for each child.

Second Step was generally more effective in Head Start classrooms than in child care classrooms. Head Start children, especially the most aggressive children, who received Second Step showed a significant decrease in the number of conflicts in which they engaged and in their use of antisocial strategies to resolve them. However, the most aggressive children also showed a significant decrease in prosocial strategies. This may result from the fact that fewer conflicts lead to fewer opportunities to demonstrate prosocial strategies.

In child care classrooms, children exposed to Second Step showed a significant increase in both the number of conflicts in which they engaged and their use of prosocial strategies to resolve those conflicts. The most aggressive children in child care showed a significant decrease in antisocial strategies regardless of whether they were exposed to Second Step or not. The least aggressive child care children exposed to Second Step showed significant increases in number of conflicts, antisocial strategies, aggressive strategies, and aggression scores on the PBQ. These findings suggest that exposure to a violence prevention curriculum may have the unintended side effect of focusing nonaggressive children's attention on aggressive and antisocial strategies, thereby leading them to try out these novel behaviors.

Second Step may have been more effective in Head Start classrooms because in the beginning of the study, the children in Head Start engaged in significantly more conflicts and used antisocial strategies to resolve those conflicts more often than did the children in child care. In addition, the cumulative nature of the Second Step curriculum may have made it more difficult for child care teachers to implement because child turnover is more common in their classrooms. Finally, Head Start teachers were more enthusiastic about the curriculum at least in part because they were more familiar with implementing premade curricula. The child care teachers in this study had typically developed their own curricula; therefore they were not enthusiastic about using a "canned" curriculum.

References

Behar, L. & Stringfield, S. (1974). *Preschool Behavior Questionnaire, Scale and Manual.* Durham: Learning Institute of North Carolina.

Huesmann, L. R., Eron, L. D., Lefkowitz, M. M., & Walder, L. O. (1984). Stability of aggression over time and generations. *Developmental Psychology, 20*(6), 1120-1134.

Tolan, P. H., Guerra, N. G., & Kendall, P. C. (1995). A developmental-ecological perspective on antisocial behavior in children and adolescents: Toward a unified risk and intervention framework. *Journal of Consulting and Clinical Psychology, 63*(4), 579–584.

Can Early Childhood Intervention Prevent High School Dropout? Evidence From the Chicago Child-Parent Centers

Judy A. Temple, Arthur J. Reynolds, Wendy T. Miedel

PRESENTERS: Judy A. Temple, Arthur J. Reynolds

We investigated the effects of participation in the Chicago Child-Parent Center program from ages 3 to 9 on early school dropout measured at approximately age 17. The Child-Parent Centers offer a government-funded educational intervention program from preschool through second or third grade in 20 locations in Chicago's poorest neighborhoods. Using data from the Chicago Longitudinal Study, we addressed two major questions: (a) Is participation in the Child-Parent Centers associated with a lower rate of high school dropout? (b) Which nonintervention variables predict high school dropout?

Although there is strong evidence that good-quality early childhood interventions have

meaningful effects on scholastic and social development (e.g., Barnett, 1995), more could be known about the longer-term effectiveness of large-scale intervention programs administered through human service organizations and schools. The lack of long-term evidence is particularly striking for high school graduation, an outcome that is a major predictor of future socioeconomic status and earnings.

Very little evidence is available on the longer-term effects of interventions that are extended beyond preschool. A recent analysis of the Title 1B-funded Chicago Child-Parent Centers demonstrated that students who participated in an educational intervention that extended from preschool into the early primary grades had better school performance at the end of grade 7 than did students who participated only in the preschool component of the intervention (Reynolds & Temple, 1998). The current study investigates the relation between extended program participation and high school dropout.

Data were drawn from the Chicago Longitudinal Study, a prospective study that traces the school performance of approximately 1,500 minority students from high-poverty neighborhoods who entered public kindergartens in 1985. If still in school, continuously promoted students were expected to graduate in spring 1998. Information on school progress was available for 1,159 students of the original 1,539 students, reflecting a sample retention rate of 75%.

Approximately one third (34.3%) of the 1,159 students had dropped out of school as of January 1998. Boys had almost a 40% dropout rate, while the rate for girls was just below 30%. Students who participated in the Child-Parent Center intervention for 5 or 6 years had a dropout rate of 27.4%, which is significantly less than the overall rate.

Results were reported from regression analyses that investigate the relation between program participation and high school dropout while controlling for a variety of student and family characteristics, such as kindergarten achievement, family low-income status and parent education. Nonrandom attrition was controlled for using econometric techniques. Findings indicated that early high school dropout be predicted by a number of student and family characteristics. Consistent with Ensminger and Slusarick (1992), findings showed dropout can be predicted by early achievement and a family's low-income status in the early years of grade school. Importantly, results indicated that high school dropout can be predicted by participation in the preschool component of the intervention program. The strongest effects of program participation on high school dropout, however, were for these students who participated in the extended intervention for five or six years. Evidence suggested that some of the longer-term effects of the intervention on the high school dropout rate operated indirectly through reduced school mobility and lower rates of special education placement and grade repetition.

References

Barnett, W. S. (1995). Long-term effects of early childhood programs on cognitive and school outcomes. *The Future of Children.* Center for the Future of Children: Los Angeles, CA.

Ensminger, M. E., & Slusarcick, A. L. (1992). Paths to high school graduation or dropout: A longitudinal study of a first-grade cohort. *Sociology of Education, vol. 65.*

Reynolds, A. J., & Temple, J. A. (1998). Extended early childhood intervention and school achievement: Age 13 findings from the Chicago Longitudinal Study. *Child Development, 69,* 231–246.

Partnering for Prevention: A Collaborative Intervention for Toddlers and Preschoolers

Pamela B. Miller, Kathleen A. Ivins, Catherine Ayoub

PRESENTERS: Pamela B. Miller, Kathleen A. Ivins, Catherine Ayoub

The Risk and Prevention Program of the Harvard Graduate School of Education trains interns in human services and educational practice through partnerships with community-based child and family intervention programs. In this presentation, key elements of these partnerships were identified, collaborative processes were described, and the utility of these collaborations was assessed.

We have learned that successful partnerships involve actively building relationships with onsite partners throughout both the initial development of the collaboration and its ongoing sustainment. Key components include flexibility and adaptability from all parties, mutual commitment to the goals of the partnership, and guidelines that are clearly stated at the outset, but that can also be adapted to the developing needs of the partners (Mattessich & Monsey, 1994).

These newly created partnerships among community sites and the university must, by definition, involve innovative patterns of interaction (Harvard Family Research Project, 1993). We have also, however, devised several means by which to nurture these efforts so that our collaborative patterns can coexist with well-established relationships already operating within the service delivery system. For example, we have key administrators involved in all phases of the collaboration. Together we develop common goals with explicit expectations for the training of graduate students, simultaneously acknowledging both university requirements and service model needs.

The evaluation of our interactions with early childhood sites is primarily qualitative. In order to assess the five early childhood partnerships effectively, we continuously monitor and assess our relationships with staff through formal and informal means. In addition, students provide extensive feedback about their activities at the site and their relationships with administrators, staff, and children. In keeping with the stated goal of ongoing compromise and communication among collaborators, we use this information to provide feedback to students, staff, and trainers.

References

Harvard Family Research Project (1993). *Collaboration: Building villages to raise our children.* Cambridge, MA: Harvard Family Research Project.

Mattessich, P. W., & Monsey, B. R. (1994). *Collaboration: What makes it work?* St. Paul: Wilder Foundation.

Parent-Child Conflict Resolution: The Peaceful Kids, Safe Kids Program

Sandra V. Horowitz, Kathleen Mayo Cochran

PRESENTERS: Sandra V. Horowitz, Kathleen Mayo Cochran

The Peaceful Kids, Safe Kids Conflict Resolution Program for preschoolers and their parents was developed and tested in six day care centers under three conditions: parent-child-staff, staff-child training, and control. Children in the parent condition showed greater improvement in skills and behavior than did others. Parental discipline also improved.

(Abstract from original proposal; paper summary not available for publication.)

Variability in Implementation of a Preschool Resiliency-Based Prevention Initiative: Relationship to Child Outcomes

Kathleen Bodisch Lynch, Susan R. Geller

PRESENTERS: Kathleen Bodisch Lynch, Susan R. Geller

The relationship between the fidelity of implementation of a preschool prevention initiative and child behavior outcomes was examined for the Resilient Children Making Healthy Choices Project (RCMHC). The project was implemented in 18 Head Start and other community-based preschool classrooms in Virginia during 1995 and 1996, with seven similar classrooms serving as comparison sites. Participating teachers were trained to implement RCMHC's prevention curriculum, reinforce resiliency-based concepts and skills in naturally occurring situations throughout the day, and use a facilitative teaching approach to support children's development of resiliency characteristics. Faithful delivery of the intervention required teachers to: (a) implement the RCMHC curriculum in its entirety, (b) communicate the content effectively by conducting each lesson according to the directions provided, and (c) use facilitative skills, such as helping children brainstorm and explore ideas, validating children's feelings and experiences, guiding problem-solving, and allowing children to choose self-control. Integrity of implementation was measured through staff observations and ratings of teachers' fidelity to content and approach on multiple occasions, using RCMHC's 13-item Implementation Monitoring and Observation Form (IMOF). Child outcomes were measured by teachers' pre and postratings, using RCMHC's Child Behavior Rating Scale (CBRS), designed to assess resiliency-related behaviors. ANOVA results indicated that ratings of teachers' implementation of the intervention improved significantly over time; mean ratings increased from 3.77 to 4.15, out of a maximum of 5.00, from initial to final observation (n=16, F=6.72, p<.05). To determine whether variability in fidelity of implementation was related to differences in child behavior outcomes, the teachers were divided into two groups according to their average ratings on the implementation measures. Ten teachers were categorized as "high implementors" and seven were categorized as "low implementors." Repeated measures ANOVA results indicated that children of high implementors received significantly higher postprogram ratings on the CBRS than children of low implementors (means of 3.90 and 4.12 respectively, out of a maximum rating of 5.00; n=230, F=12.75, p<.000). Intervention children overall (i.e., high and low implementors combined) received higher ratings than children of nonimplementors (i.e., comparison group children); CBRS means were 4.06 and 3.60 respectively (n=333, F=38.55, p<.001). Research on implementation processes for preventive interventions is relatively new (Durlak, 1995), even though the need to examine variability in program implementation as a mediator of program effectiveness has long been noted (Hall & Loucks, 1977; Scheirer & Rezmovic, 1982). Results of this study confirm the importance of implementation evaluation. Differences in child behavioral outcomes were related to the degree to which the RCMHC intervention was implemented with integrity. Children of teachers rated as high implementors made greater gains than children of low implementors, and both groups made greater gains than comparison group children who did not receive the intervention.

References

Durlak, J. A. (1995). *School-based prevention programs for children and adolescents.* Thousand Oaks, CA: Sage.

Hall, G. E., & Loucks, S. F. (1977). A developmental model for determining whether the treatment is actually implemented. *American Educational Research Journal, 14,* 263–276.

Scheirer, M. A., & Rezmovic, E. L. (1982). *Measuring the degree of program implementation: A methodological review.* Rockville, MD: Westat.

Head Start on Science

William C. Ritz, Ruth Von Blum

PRESENTERS: William C. Ritz, Ruth Von Blum

Although Head Start has had a powerful impact on the nation's children, most Head Start programs, regardless of their large-scale success, have lacked a science component. Indeed, for too many Head Start teachers, teacher aides, and home visitors, the word "science" conjures up some very uncomfortable feelings and memories. This realization prompted William Ritz of the Department of Science Education at California State University, Long Beach, to join with the Head Start program of the Long Beach Unified School District (LBUSD) to create the "Head Start on Science" project. Funded primarily through a grant from the US Department of Health and Human Services, the project prepares Head Start staff to become more capable, comfortable, confident, and enthusiastic about their own and their programs' families' "sense of wonder" about the world through hands-on science experiences.

The program has developed a rich curriculum of more than 100 science activities, and it conducts summer institutes for Head Start teachers in which they participate in hands-on science activities and practice techniques of facilitated learning (using open-ended questioning strategies, acknowledging children's responses, etc.). Follow-up "friendly visits" by project staff to the classrooms provide ongoing support, and periodic follow-up meetings provide opportunities for field trips and the sharing of experiences. Each participant receives a guide containing Head Start On Science activities in addition to a small start-up set of science supplies in a tote bag. The program has been tested and refined with additional Head Start agencies in Los Angeles County, California, and Syracuse, New York.

Evaluation activities have included a baseline study of reactions to science tasks, an assessment of training and classroom activities, a review of teacher feedback, and documentation of classroom visits. Findings show a marked improvement in both the quality and quantity of science experiences the children receive. For example, in LBUSD, although only 63% of the teachers reported being "comfortable" or "very comfortable" with science before the program, 95% felt so at midyear during the program. Likewise, the percentage of teachers who reported doing science every day rose from 35% to 63% after training, with 80% (as opposed to 51%) reporting doing science at least two to three times a week. Classroom observations bore out the enhanced role of science within the Head Start classrooms and increased use of facilitated learning strategies by the teachers. One of the most important evaluation findings is that by encouraging a "sense of wonder" among children, the teachers seemed to lose their own fears of science.

Comments from Head Start teachers were uniformly very positive. The following is a typical example:

> I came here thinking that this was going to be another boring class with nothing but lectures, formats, and a lot of writing. Boy, oh boy, was I wrong. There was so much hands on. I did everything. It opened my sense of wonder. Thanks. Believe me, when I go back to my classroom, my science area is going to be a lot bigger, and I will teach it to my children in the same fun way all the facilitator leaders taught me.

Early Education

Supporting Early Learning at the U.S. Department of Education

Naomi Karp, Carol Sue Fromboluti, James Griffin, Donna Hinkle

PRESENTERS: Naomi Karp, Carol Sue Fromboluti, James Griffin, Donna Hinkle

The National Institute on Early Childhood Development and Education was established in October, 1995 to carry out a comprehensive program of research, development, and dissemination to improve early childhood development and education. The Early Childhood Institute (ECI) is the only office within the US Department of Education that focuses solely on the school readiness of young children. The ECI sponsors coordinated and comprehensive research, development, and dissemination activities that investigate which factors, including services and support, improve the learning, cognitive, social-emotional development, and general well-being of children from birth through age 8.

The ECI currently funds the National Center for Early Development and Learning (NCEDL) at the University of North Carolina at Chapel Hill. The research of the Center provides early childhood educators, policymakers, researchers, and families with new information about the effect of the quality of early childhood services on children's later success in school, and about how family-centered, community support systems can provide effective interventions for children at risk for school failure. The ECI also contributes to the support of the Center for the Improvement of Early Reading Achievement (CIERA) at the University of Michigan. The Center conducts research on early reading acquisition and on the strategies that foster this learning, including strategies to be used by families, child care and preschool personnel, and kindergarten and elementary school teachers.

The Institute's Field Initiated Studies (FIS) program supports projects that are proposed by the early childhood research field. Early Childhood Institute-supported FIS research projects have greatly expanded the breadth and quality of studies being conducted on how young children learn and the most effective methods for promoting children's learning and development. Examples of ongoing research include assessing curriculums for early literacy and numeracy skills, testing ways to enhance children's school readiness, and evaluating a new intervention which helps preschoolers and their families cope with neighborhood violence.

The ECI currently oversees the Early Childhood Research Working Group, which is compromised of 100 representatives from 30 federal agencies, across nine departments, that have research, data, and statistics responsibilities, or support programs which focus on young children and their families. The purposes of the working group are to share information across agencies and to support collaborative research projects. The ECI currently has interagency agreements with the National Institute of Child Health and Human Development (NICHD), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute of Justice (NIJ).

The ECI is funding the National Academy of Sciences (NAS) to conduct a study of early childhood pedagogy. This project will examine the research and theory of early childhood pedagogy (the study of teaching) across disciplines and countries as it applies to children ages 2 to 5, and will provide the basis for policy decisions based on the state of research related to early childhood education. This study follows the recently released NAS report on Preventing Reading Difficulties in Young Children, which was also supported by the ECI.

A Head Start Transition Project in the Public Schools: Teacher and Principal Beliefs of Program Implementation

Stacey Neuharth-Pritchett, Panayota Youli Mantzicopoulos

PRESENTERS: Stacey Neuharth-Pritchett, Panayota Youli Mantzicopoulos

The successful implementation of any educational intervention, including those that target low-income children and families, is affected by the constraints that have plagued school reform efforts for decades. Without understanding the complexity of the school change phenomenon with the provision of services for economically disadvantaged children, our understanding of the impact of early intervention programs on participants remains unclear. Research on the maintenance of cognitive and socioemotional gains for former Head Start children suggests that the benefits of the intervention are short term. Perhaps this result is an artifact of unsuccessful school-supported transitions or a lack of support structures in elementary schools to enable maintenance of these gains.

This investigation provided insights on the complexity of the school change process with the provision of services for economically disadvantaged children. Data from 70 participants indicated that a number of barriers operated at different levels to inhibit the reform effort in one school system. Beginning with the premise of serving low-income children and their families, the change process within this school system was ultimately characterized as a conflictual struggle for program control. The initial vision of the program was affected by the inability to survive the unpredictable character of the change process and was eventually transformed by the central office administrators into a bureaucratic network of policies and procedures. Although intended to improve the program structure, this action did little to facilitate the service delivery to children and families, as is evidenced by the destruction of the collaborative culture that characterized the first 3 years of the Transition Program.

The cohesiveness and bonds formed between the Head Start Center and Transition staff during the first 3 years of implementation became the target of destructive interactions among teachers, staff, and administrators upon the appointment of a new school leadership. An atmosphere was created that contributed to the destruction of the professional community and positive interactions that had characterized the program during its infancy. The focus of the intervention moved from a concern for the diversity of needs encountered by children and their families in schools to a struggle for control of a program that participants characterized as lacking direction and focus.

Data indicated that a culture change was not established and this ultimately led to an inability to implement and institutionalize the Transition Program. Lack of support by the central administration as an agent to facilitate a cooperative environment did not promote risk-taking and professional development. This constrained the teachers' collective engagement in sustained efforts to improve practice and resulted in teachers' retum to known practices as a means to diminish the strain between what the Transition Program and the school system asked of them. The most significant impediment to this reform effort was the lack of alternative or multiple voices in the decision-making process in the program's implementation. Together with the dismissal of parental voices in the program, teachers were given little control over the implementation process, which resulted in a lack of institutionalization of the Transition Program in the school system.

The Early Childhood Education and Assistance Program Longitudinal Study: 1988–1997

Jane A. Grimstad, Mary W. Frost

PRESENTERS: Mary W. Frost, Jane A. Grimstad

The State of Washington has operated a statewide system of comprehensive early childhood education and assistance services for more than 10 years. The Early Childhood Education and Assistance Program (ECEAP) was authorized by the State of Washington Early Childhood Assistance Act of 1985. The ECEAP is a community-based, family-centered, comprehensive preschool program for low-income 4-year-olds and their families. The primary goal of the ECEAP is to foster a greater degree of educational and social proficiency in children from low-income families. The second goal is to provide enhanced learning opportunities for children at risk of school failure.

The authorizing legislation for ECEAP included a legislative requirement for an external evaluation. The evaluation was included in the Act in order to assess the effectiveness of preparing economically at-risk children for success in school and assisting their families in supporting and participating in their children's development and success. Since 1988, the Northwest Regional Educational Laboratory (NWREL) has been conducting a longitudinal study of the ECEAP.

The ECEAP Longitudinal Study employs a quasi-experimental design to measure outcomes of low-income children and their families who are enrolled in the ECEAP. The central purpose of the study is to assess the ECEAP's effectiveness in preparing economically disadvantaged children for success in the educational system. The study tracks a sample (N=1358) of ECEAP children and families from ECEAP enrollment through the twelfth grade or the equivalent. The sample consists of three successive cohorts of ECEAP participants beginning in 1988. Study families were assessed at the beginning and end of their preschool year and are being assessed annually each spring from kindergarten through twelfth grade. The ECEAP sample is compared with that of a matched sample (N=322) of children who were ECEAP-eligible, but not served. Annual assessment includes a parent interview, review of school records, teacher reports of academic progress, and a self-report survey conducted with study subjects beginning in the seventh grade.

The findings of the study show strong indication that the program is successful in achieving the overall goal of bringing about a greater degree of educational and social proficiency in children from low-income families. In addition, a trend of increasing importance placed on parental participation in children's growth and education over time has emerged with ECEAP parents while a trend of decreasing importance emerged with comparison parents.

Additionally, family income had an effect on the findings of this study. In general, regardless of study group membership, income was the driving force behind teachers' perceptions of student behavior and achievement. Children from families with lower incomes were consistently rated as having poorer and more negative outcomes than their more advantaged counterparts. This study has provided an opportunity to examine the effect of income on educational and social outcomes. Despite extra resources from the Chapter 1 compensatory education program, educational restructuring, educational reform, and the effective teaching movement, the children of poverty continue to experience disproportionate educational failure. As the study children move into adolescence and additional data are collected, the pathways to the various outcomes will continue to be examined.

Teaching Basic Skills in a Model Public School

Laura C. Bell, Carol F. Reich, Sonia Ortiz-Gulardo

PRESENTER: Laura C. Bell

High standards for academic achievement, especially in literacy learning, were a high priority in the design of the Beginning with Children School. Unfortunately, high standards for teaching, learning, and measuring literacy have not been a salient feature of teacher education for the last 10 to 15 years. As a result of long-standing debates around whole-language and standardized testing, both teaching and measurement standards and, ultimately, student achievement have been weakened.

The whole-language debate has produced teachers who have come to see reading as a "natural" process (like language) that develops as the child interacts with the world. Reading is, in fact, a very unnatural process based on a man-made code that needs to be taught to children in a very direct style.

Similarly, while there is a resurgent interest in national standards, the original argument against standardized tests prevails in schools. The result has been: (a) teachers' refusal to judge student performance against anything but the child's own prior performance; (b) a resistance to quantifiable measures of performance; and (c) a rejection of age-and-grade level standards for all children.

At the juncture of these two movements is the low-income, urban child, who has the same ability to succeed as his counterparts in middle- and upper-middle-class homes, but who does not have the same knowledge base. Children from low-income families often have little experience with written and spoken language, numbers, and other educational precursors of later school learning. Children who have an enriched preschool experience have learned the rudiments of reading and math before they enter kindergarten and may not require a teacher to teach lower-level reading and math skills like the alphabetic principle, word decoding, letter-sound correspondence, counting, and categorization. A child from a low-income family, on the other hand, needs to have this information provided in school in an accelerated and direct way.

At Beginning with Children, we have found that a tripartite program that integrates individual student assessment, curriculum development, and staff development is most effective in addressing the shortcomings of teaching and learning that have been observed in recent years in urban schools. Individual assessments of language ability and early-developing reading and math skills are administered in kindergarten and at the end of every year thereafter, thereby enabling teachers to follow a child's progress in learning, adjust their curricula, and seek help to develop their own skills if necessary. The success of this approach is demonstrated by the Beginning with Children students' current test scores: 60.4% of children in third to sixth grade are reading at or above grade level, compared to 49.9% of third to sixth graders system-wide. In addition, 82.5% of our students are at or above grade level in math. Currently, citywide math averages are not available.

Cognitive Gains From Extended Play at Classification and Seriation

Kimberly N. Garrett, Rosetta F. Busby, Robert Pasnak

PRESENTERS: Kimberly N. Garrett, Rosetta F. Busby, Robert Pasnak

A "learning set" of 80 classification games and 65 seriation games was used to teach the oddity principle and insertion into a series to 15 Head Start 4-year-olds. These games were played with the children for a period of 4 months using toy ponies and hand puppets as props. At the conclusion of this form of instruction, these children were significantly better than a companion class of Head Start children at both classification and seriation. This modest but statistically significant superiority extended from problems involving three-dimensional objects to two-dimensional representations of oddity and seriation problems.

The children's improvement has positive implications for transition to grades K-3, since it has been shown independently that mastery of classification and seriation at the outset of kindergarten predicts achievement at the end of kindergarten and for the next 3 years. Also, remedial instruction on the oddity principle and seriation produces lasting improvements in the academic performance of children who have difficulty understanding kindergarten work. Receiving this instruction in Head Start should spare these children from this cognitive difficulty and, consequently, their academic performance should benefit. Whether or not this expectation is well founded is a fit topic for future research, as is the possibility of improving preschool instruction to produce a more complete mastery of classification and seriation.

Training Rural Child Care Providers: Results of Project REACH

Linda M. Espinosa, Michelle Mathews, Kathy Thornburg, Jean Ispa

PRESENTER: Linda M. Espinosa

The conditions and characteristics of child care throughout rural America have not been carefully researched or adequately described. Relatively little is known about the child care arrangements, the quality of care available, or the training needs of rural child care providers. The purpose of this investigation was to: (a) learn more about the conditions of child care in rural Missouri, and (b) evaluate the effectiveness of a training program focused on rural child care providers.

Although there is some research suggesting that rural and urban communities differ with respect to variables of concern to early childhood educators, "the vast majority of recent child care research has either used strictly urban samples or, when rural participants have been included, has failed to distinguish between the two groups" (Atkinson, 1994; Thornton, Mathews, Espinosa, & Ispa, 1997).

There is also scant research investigating how training is best delivered to rural populations, the impact of individualized training, or who benefits most from training. Project REACH was established to: (a) provide individualized training and support to caregivers living in rural and isolated areas of Missouri; (b) provide onsite, ongoing mentoring and support regarding developmentally appropriate practices; (c) facilitate the awareness and utilization of existing community resources for participating caregivers and families; and (d) to develop articulation mechanisms between the local public school and the child care community to improve the transition from preschool to kindergarten.

The specific purpose of this study was to answer the following questions: (a) What are the characteristics of rural child care providers? (b) Can an intensive, individualized training program increase the knowledge, attitudes, and overall quality of care provided by rural

caregivers? (c) What characteristics of rural providers predict their participation rates in child care training? and (d) Do participation rates predict improvements in child care quality?

Seventeen rural communities in seven counties were selected based on high poverty rates, need for additional child care, and lack of existing training resources. One hundred and fifteen child care providers who participated in Project REACH were assessed prior to, during, and immediately after a year long, individualized training program. The Teacher Beliefs Scale was administered to each caregiver. The quality of each child care setting was assessed through direct observation. The Early Childhood Environment Rating Scale or the Family Day Care Rating Scale was used to assess the overall quality of care and education provided to children. The quality of the caregiver-child interactions was assessed with the Caregiver Interaction Scale.

The results reveal a profile of rural child care providers that differs from urban providers. Although the initial quality of care was rated as inadequate, significant improvements in practices, beliefs, and interactions were documented during the training. The child care providers improved not only their global quality of care, but also the quality of their interactions with the children in their care.

Toddler Day Care Quality and NAEYC Accreditation

Karen L. Murphy, Elisa L. Klein

RESENTERS: Karen L. Murphy, Elisa L. Klein

This study was undertaken to explore the relationship between National Association for the Education of Young Children (NAEYC) accreditation, quality scores on the Infant/Toddler Environment Rating Scale (ITERS; Harms, Cryer & Clifford, 1990), and caregiver-child interaction as measured by a time sampling observation technique in infant and toddler child care settings.

Eight centers identified as either NAEYC accredited, in the process of receiving accreditation, or non-accredited were included in the sample. Within each level of accreditation there were three infant classrooms and three toddler classrooms for a total of 18 classrooms. Each classroom was observed on two occasions and scored on the ITERS as well as the caregiver interaction checklist. The ITERS consists of seven subscales: furnishings and display, personal care routines, listening/talking, activities, interaction, program structure, and adult needs. The interaction checklist requires a 20-minute observation period during which each caregiver is rated as interacting or not interacting at 15-second intervals. After completing the checklist, a percentage of interaction was calculated for each caregiver.

Accreditation status was found to be related to child care quality as measured on the ITERS. Overall, classrooms that were in the process of accreditation scored highest on the ITERS. A two (age) by three (accreditation status) ANOVA yielded significant group differences for overall score, $F(2, 17)=4.55$, $p<.05$, as well as for furnishings and display, $F(2,17)=9.63$, $p<.01$ (with in-process centers scoring highest), and for adult needs, $F(2,17)=.5.12$, $p<.05$ (with accredited centers scoring the highest). All groups scored high (good to excellent) on the interaction subscale of the ITERS and there were no significant accreditation group differences on the interaction checklist. The ranges showed considerable variation within groups, however. Caregivers in the accredited group ranged from 8–99% involvement while the other two groups did not show quite as broad a range (in-process range=11-94%, non-accredited range=15–84%).

Reference

Harms, T., Cryer, D., & Clifford, R. M. (1990). *Infant/toddler environment rating scale.* New York: Teachers College Press.

The Longitudinal Effects of a Statewide Preschool Program for At-Risk Children and Their Families

Kim Townley, Mary Louise Hemmeter, Stephan Wilson, Ann Epstein, Hui Hines

PRESENTERS: Kim Townley, Mary Louise Hemmeter, Stephan Wilson, Ann Epstein, Hui Hines

Findings of an ongoing, longitudinal study of children at risk for school failure were presented. Since 1990, over 2,700 children have been followed to assess the impact of the Kentucky Preschool Program (KPP) on children's success in school. The KPP is a tuition-free statewide preschool program created in 1990 to help at-risk children reach their full potential. The development of the KPP involved a review of developmentally appropriate practices (Bredekamp & Copple, 1997), integrated services, and interagency collaboration (Capone & DiVenere, 1996). The KPP serves 4-year-old children from low-income families and 3- and 4-year-old children with disabilities. Each school district is required to make services available to all eligible children, either through district-provided programs or contracts with other public or private service providers. Local school districts collaborate with Head Start to maximize use of federal funds.

An evaluation of these programs has been conducted for the last 6 years. The questions that have been addressed include the following: (a) What is the quality of the KPP? (b) What child outcomes occur as a result of participation in the KPP? (c) What is the relationship between program quality and child outcomes? (d) How does the KPP prepare children for kindergarten? and (e) How do children perform in school over time as a result of participating in the KPP?

In order to answer these questions, both quantitative and qualitative methods were used. For the first 5 years of the project, quantitative methods were primarily used. Preschool children were tested during the fall and spring using the Battelle Developmental Inventory (Newborg, Stock, & Wnek, 1988) and two measures of early literacy skills. Parents and preschool teachers completed a social skills questionnaire about each child. Data were also collected on children as they entered kindergarten. Three groups of children were included: (a) children who had attended the KPP; (b) children who were eligible for the KPP but who had not attended; and (c) children who were not eligible for the KPP. Teachers completed two questionnaires regarding children's transition to kindergarten and their developmental status. In addition, each child was assessed using the Preschool Language Scale-3 (Zimmerman, Steiner, & Pond, 1992) and parents and kindergarten teachers completed a social skills questionnaire for each kindergartner.

During the 1997–1998 evaluation, the relationship between program quality and child outcomes was assessed in five classrooms through classroom observations, interviews with teachers and parents, child assessment, and parent and teacher surveys.

References

Bredekamp, S., & Copple, C. (Eds.). (1997). *Developmentally appropriate practice in early childhood classrooms*. Washington, D.C.: NAEYC.

Capone, A. M., & DiVenere, N. (1996). The evolution of a personnel preparation program: Preparation of family-centered practitioners. *Journal of Early Intervention, 20*(1), 222–231.

Newborg, J., Stock, J. R., & Wnek, L. (1988). *Battelle developmental inventory*. New York, NY: Riverside Publishing Company.

Zimmerman, I. L., Steiner, V. G. & Pond, R. E. (1992). *The preschool language scale-3*. San Antonio, TX: The Psychological Corporation, Harcourt, Brace, Jovanovich, Inc.

Adult Perceptions of Young Children's Play Behaviors

Carol C. Torrey, Susan G. Cooper

PRESENTER: Carol C. Torrey

The purpose of this study was to evaluate congruence of parents' and preschool teachers' perceptions of child play, and to compare the difference in perceptions of African American and White parents. The Attitudes about School and Play questionnaire (Johnson, 1982) was used to determine perceptions of child play. The questionnaire was composed of 18 items arranged in a paired comparison format. Respondents were required to choose among two play activities, determining which activity was more important for a 4-year-old child to engage in while at school. The activities represented four categories: content skills, process learning, convergent play, and divergent play.

Parents of children in 2 of 11 centers in the Regina Coeli Head Start Program in Southeast Louisiana were asked to participate in this study. These centers were chosen due to their ethnic composition, which provided approximately 50% African American and 50% White participation. Each participant completed the Attitudes about School and Play questionnaire and a demographic survey. Additionally, teachers and aides from all Regina Coeli Head Start Programs in the region were asked to participate, and completed the Attitudes about School and Play questionnaire several weeks after parent participation.

One-hundred ninety-nine parents (78%) and 86 teachers and aides (100%) completed the questionnaire. Parent responses indicated a ranking of play categories in the following order of importance: content skills (M=6.94), process learning (M=4.50), convergent play (M=4.11), and divergent play (M=2.45). Teachers and aides indicated the following category ranking: divergent play (M=6.21), convergent play (M=5.63), process learning (M=3.62), and content skills (M=2.55). T-tests were completed and significant differences between parents and teachers/aides were found for content skills and convergent play. When responses of African American parents were compared to White parents, the categories were ranked in an identical order. There were no significant differences between parent groups.

In the past decade, quality preschool programs for young children have highlighted developmentally appropriate practices (Fox, 1996). Child initiated and directed play, convergent play, divergent play, and process learning have been favored over more traditional learning of content skills through teacher directed activity (Guddemi, 1992). The teacher responses in this research were indicative of this trend toward developmentally appropriate practice. In contrast however, learning of content skills was clearly determined by the parents to be more important than the other play categories. This lack of congruence between teachers and parents may affect the learning and development of children in preschool programs. When families and school personnel are in agreement with curriculum content and teaching methods, learning may be positively enhanced (Brewer & Kieff, 1996/1997; Farver, Kim, & Lee, 1995). Families will reinforce school learning at home.

References

Brewer, J. A., & Kieff, J. (1996/1997, Winter). Fostering mutual respect for play at home and school. *Childhood Education*, 92–97.

Farver, J. M., Kim, Y. K., & Lee, Y. (1995). Cultural differences in Korean- and Anglo-American preschoolers' social interaction and play behaviors. *Child Development, 66*, 1088–1099.

Fox, J. E. (1996). Back to Basics: Play in early childhood. *Early Childhood News, 8*(5), 19–24.

Guddemi, M. (1992, May). *The child's right to play.* Paper presented to the United Nations Press Conference, New York, NY.

Johnson, J. E. (1982). *The attitudes about school and play questionnaire.* Unpublished manuscript.

Turnbull, A. P., & Turnbull III, H. R. (1997). *Families, professionals and exceptionalities.* Upper Saddle River, NJ: Merrill.

Curriculum Construction: A Study of Utilization of Cross-Age Tutoring

Hengameh Kermani, Mahnaz Moallem

PRESENTERS: Hengameh Kermani, Mahnaz Moallem

The purpose of this study was to explore peer tutoring from Vygotskian and Piagetian perspectives. It was a collaborative effort between two researchers and eight teachers from four elementary schools. Fifty fourth and fifth graders were paired with 50 kindergartners to create dyads on the basis of competence and academic levels, gender, and ethnicity. There were 15 African American and 35 Anglo American children in each age group. The teachers and researchers preselected collaboratively the tasks involved on the basis of kindergartners' cognitive ability and the fourth and fifth graders' knowledge base. The tasks' content included concept learning (measurement), problem solving (absorption), and procedural rules (story writing). To examine the effects of training on the quality of peer interactions, tutors from two different sites received training on interpersonal, management, and content skills prior to tutorial sessions.

The data were collected and transcribed verbatim for six consecutive sessions, once a week for 1 hour, via audio- and videotapes. Students' learning outcomes and their attitudes toward tutorial sessions were assessed using preselected performance criteria and open-ended questions respectively. The fourth and fifth graders' self-esteem and kindergartners' cognitive and social skills were also measured pre and posttutorial program. Fieldnotes were used to document the formal and informal discussions with cooperative teachers throughout the duration of the program.

The preliminary analysis of the data is based on two tasks, problem solving (absorption) and procedural rules (story writing), and 17 dyads (9 trained, 8 not trained) from two schools. The analysis is still in process for the remaining tasks and dyads. The dyad's interactional behavior was transcribed and coded directly from the videotapes. Both tutors' and tutees' behaviors are reported in terms of actual frequency or number of times each behavior occurred over the tutorial session. Categories for tutors' and tutees' verbal and nonverbal behavior were coded on the basis of mutual engagement during tutorial sessions. These categories were adapted from Kermani and Moallem's synthesis of previous analyses of cross-age tutoring behavior. Eight dependent categories with regard to tutors' scaffolding or teaching behavior were selected: explanation, inquiry, feedback, directives, verbal cues, modeling/demonstration, responsiveness, and engagement. Qualitative analysis was also used to examine the nature of the interaction between and within dyads.

Analysis of pre and posttutors' self-esteem surveys showed no significant differences between tutors' pre-self-esteem in training and nontraining sites. However, significant differences were found between tutors' post-self-esteem in training and nontraining sites. Tutors' post-self-esteem scores in training sites were significantly higher than their pre-self-esteem scores. Analysis of teachers' perception of kindergartners' cognitive skills showed a slight change from pre to post in both training and nontraining sites. However, no change was observed in kindergartners' social behavior.

The quantitative analysis of the data showed that overall there were no significant differences in the level of interaction in either task across training and nontraining sites. However, significant differences were observed in the level of interaction across tasks within each site (training or nontraining). A more in-depth analysis of a dyad's level of interaction with varying composition showed that high-ability tutors were better able to scaffold high-ability tutees and female tutors provided more scaffolding strategies to tutees (male or female) as compared to male tutors. In addition, it was shown that male African American tutors provided less scaffolding strategies when working with female African American tutees. In summary, the findings indicate that type of task and prior training interacts with student characteristics to affect peer tutoring. The results strongly support the viability of peer tutoring as an alternative instructional strategy in improving students' social and academic skills.

Changes in Children's Play Behavior in Public School Preschools

Dale C. Farran, Whasoup Son-Yarbrough

PRESENTER: Dale C. Farran

This study described the developmental changes in children's play behaviors in public school preschools funded by Title I of the Elementary and Secondary Education Act. With a history of bringing an academic curriculum from the primary grades down to younger age groups under the auspices of "school readiness," it has been a major concern that preschools operating in the public schools might have positive effects on young children's initial readiness but at the expense of their development as a whole (Elkind, 1986; Farran, Son-Yarbrough, & Silveri, 1993; Marcon, 1993, 1994; Zigler, 1986). Subjects included 283 children in 23 preschool classrooms funded by Title I who scored at least 12–18 months behind on the eight school systems' readiness screening measures. Children's play behaviors during free play time were observed twice over the school year in the classroom using an event sampling method. Repeated measures multivariate analyses of variance (MANOVA) were conducted to examine changes in type of play, play partner, and verbal interactions across time. The effect of gender was also examined.

Findings revealed that in public preschool intervention programs for children who are educationally and economically disadvantaged: (a) children were involved most in parallel play, and the amount of parallel play increased significantly across the year; (b) associative and cooperative play decreased significantly over the school year; (c) there was no increase in the amount of time spent in symbolic interactions (e.g., pretend play), but manipulative play increased over time; (d) peer interactions and verbal interactions did not increase over time and there were no gender effects in peer or verbal interactions; and (e) an important interaction effect was obtained for gender and time related to whom the children talked. The amount of time girls talked to teachers increased over the school year, whereas boys talked less to teachers over time (but more among themselves).

This study showed that public preschools may be oriented toward preparing children for what teachers perceive to be the demands of the primary grades: work alone but next to your neighbor on your own worksheet or task, and stay occupied. While these skills are immediately adaptive to kindergarten routines, they may not be the skills necessary for economically disadvantaged preschool children to succeed in school over time.

The literature shows that at ages 4 and 5, children engage in the most complex language and social interactions during cooperative and associative play and during symbolic interactions with peers and materials (Smith and Dickinson, 1994; Van Hoorn, Nourot, Scales, & Alward, 1993). The students in these preschools had an abundance of materials available but had few interactive and symbolic experiences. Moreover, this study raises the unsettling question about what happens to boys in public school classrooms. It is alarming that during their first introduction to school, the interactions of boys with teachers actually decreased.

References

Elkind, D. (1986). In defense of early childhood education. *Principal, 65* (5), 6–9.

Farran, D. C., Son-Yarbrough, W., Silveri, B., & Culp, A. M. (1993). Measuring the environment in public school preschools for disadvantaged children: What is developmentally appropriate? In S. Reifel (Ed.), *Advances in early education and daycare,* (Vol. 5), 75–93. Greenwich, CT: Jai Press Inc.

Marcon, R. A. (1993). Socioemotional versus academic emphasis: Impact on kindergartners' development and achievement. *Early Child Development and Care, 96,* 81–91.

Marcon, R. A. (1994, November). Doing the right thing for children: Linking research and policy reform in the District of Columbia public schools. *Young Children,* 8–20.

Smith, M. W., & Dickinson, D. K. (1994). Describing oral language opportunities and environments in Head Start and other preschool classrooms. *Early Childhood Research Quarterly, 9,* 345–366.

Van Hoorn, J., Nourot, P. M., Scales, C., & Alward, K. R. (1993). *Play at the center of the curriculum.* New York: Maxwell Macmillan International.
Zigler, E. (1986). Should four-year-olds be in school? *Principal, 65* (5), 10–14.

Teacher Encouragement and Parent Involvement of African American Parents of Kindergarten Children

Karen Gavin, Daryl Greenfield

PRESENTER: Daryl Greenfield

Despite the pivotal role that teachers can play in facilitating parent-school communication, very few studies have examined the influence of teacher encouragement on parental involvement. No study, to our knowledge, has looked at this relationship in African American families with a child at risk for poor educational outcomes during the critical transition into public school. In the present study, 76 African American kindergarten children in ten kindergarten classrooms were classified at risk for poor educational outcomes based on data obtained from their teacher. The parents of these at-risk children reported their parent involvement levels and trained observers independently rated the teachers on their encouragement of parent involvement. Measures of general involvement and involvement in two specific domains, home-school communication and school volunteering, were obtained. Although parents of children with high-encouragement teachers had higher overall scores on general involvement than parents with low-encouragement teachers, these differences were not significant. Statistically significant differences between parents occurred only when their involvement in the two specific domains measured, home-school communication and school volunteering, were compared between teachers who were high and low in the encouragement of specific activities in these two areas. The implications of these findings, including designing and evaluating parent involvement programs for the large number of families with young African American children at risk for school failure, are discussed.

The Influence of Parent/Family Characteristics and Perceived Teacher Support on Maternal Involvement in Head Start

Angela R. Taylor, Sandra Machida, Margaret Sewell

PRESENTERS: Angela R. Taylor, Sandra Machida, Margaret Sewell

Today's Head Start families confront a variety of social and economic stresses that can pose serious challenges to the family-school relationship. Yet until recently, little research had been conducted concerning the factors that might serve to undermine or enhance parental involvement in Head Start. Still fewer studies have examined parent involvement from a relational perspective—that is, in terms of the quality of the relationship formed between the parent and the child's teacher. Accordingly, the purpose of the present research was twofold: (a) to explore parent and family factors associated with variation in school involvement within a sample of low-income, multiethnic Head Start parents, and (b) to determine whether a more supportive parent-teacher relationship (as perceived by the parent) is associated with a higher level of parent involvement in the child's Head Start program.

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One hundred and seven Mexican American and 70 Anglo American mothers whose children were enrolled in a center-based Head Start program participated during the fall and spring of the school year. During the fall, mothers were individually interviewed regarding the following personal and family background characteristics: (a) maternal age (in years); (b) educational attainment (high school completion); (c) employment status (employed vs. unemployed); (d) family structure (single vs. two-parent); (e) family life events; and (f) language acculturation (English- vs. Spanish-speaking). At mid year and again in the spring, mothers completed a questionnaire on which they rated their perceptions of the quality of their relationship with the Head Start teachers (perceived teacher support, perceived relationship strain) and the frequency of their participation in Head Start program activities. The Head Start teachers rated the same questionnaire items regarding the frequency of parent participation in Head Start activities. A composite index of parent program involvement was calculated by averaging the standardized scores on the parent and teacher measures.

Results of correlational and hierarchical regression analyses indicated the following: (a) perceived teacher support was associated with being less acculturated (i.e., Spanish-speaking), whereas perceived strain in the parent-teacher relationship was associated with being a single parent; (b) higher fall maternal involvement was associated with being less acculturated, being more educated, living in a two-parent family, and having a more supportive relationship with the Head Start teachers; and (c) increased maternal involvement over the school year was associated with being Mexican American, living in a two-parent family, and having a less strained relationship with the Head Start teachers.

The findings lend support to previous research indicating that parental involvement in Head Start is significantly influenced by family background characteristics, especially single-parent status and maternal educational attainment. The findings also extend prior work by highlighting the potentially important roles of parent-teacher relationship quality and cultural background factors. As expected, a supportive parent-teacher relationship was found to facilitate mothers' involvement in their child's preschool program. However, perceived strain in the parent-teacher relationship appears to decrease the likelihood that the mother will sustain her involvement over the school year. Further research is needed to uncover the particular cultural patterns underlying our finding of heightened levels of involvement among less acculturated Mexican American mothers.

A Focus Group Study of Parent Concerns and Challenges

Jolenea Ferro, Diane Powell, Jini Hanjian

PRESENTERS: Jolenea Ferro, Diane Powell

A series of parent focus groups and interviews was conducted by the Florida Center for Parent Involvement, a statewide parent resource center funded by the federal Department of Education, in order to obtain information concerning parents' needs and preferences for information and resources that could be used to guide the development of project materials and activities.

Seventy-three ethnically diverse and predominately low-income parents were asked to describe the challenges of being a parent, school readiness issues, their involvement in their children's preschool and elementary schools, and their concerns about violence. This information was obtained through seven focus groups (n=59) and 14 individual interviews. Analysis of the transcripts yielded three categories of parental concerns and issues: (a) schools; (b) parenting; and (c) special groups. Each category is expanded upon below.

Parents felt that it was important for them to take the initiative in becoming active in their

children's schools, and stressed the value of communication and teamwork with teachers. However, parents did not always feel comfortable or welcomed in their children's schools. In addition, parents expressed concerns about school safety and the negative influences of peers on their children's development and school performance. Parents recognized the importance of children being ready for school, and many reported that their children's preschool programs had done a good job of preparing children and had been a valuable support to them as well. Parents wanted information about what would be expected of their children in kindergarten and what they could do at home to help prepare their children.

Sibling rivalry was a major focus of discussion, with jealousy and competition for parental attention viewed as underlying causes, especially when siblings had different fathers. Parents were very concerned about instilling strong values and promoting self-esteem in order to help children resist the negative influences they would inevitably encounter from the media and peers. The pervasiveness of media, family, and community violence in their children's lives was a particular concern. Parents felt that being able to maintain open communication with their children and talk with them about violence and other sensitive topics was critical to their children's healthy development. Being good role models for their children was also seen as important. Factors that were believed to influence parenting ability included the stressors in their lives and their well-being, including their self-esteem, and ability to form healthy relationships and control anger. Finally, parents wanted to find ways to connect with other parents to form supportive relationships.

Men perceived themselves as firmer disciplinarians than women, viewed this as a frequent source of conflict, and believed that communication between parents was key to sharing parenting responsibilities. Spanish-speaking participants noted that language differences created barriers and misunderstandings not only in communicating with school personnel but also in communicating with children.

These results have been used by the Florida Center for Parent Involvement to guide the selection of topics, formats, and dissemination strategies for resource materials and training workshops. The results also have implications for family involvement and support practices of schools and other family service programs.

Parent Involvement in Early Intervention for Disadvantaged Children: Does It Matter?

Wendy T. Miedel, Arthur J. Reynolds

PRESENTER: Wendy T. Miedel

This study, part of the Chicago Longitudinal Study (Reynolds, Bezruczko, Mavrogenes, & Hagemann, 1996), investigated the relation between parent reports of participation in early childhood intervention and children's rate of grade retention and reading achievement in kindergarten and eighth grade. The study sample included 704 parents who were interviewed retrospectively in 1997 about the frequency of their involvement and the number of activities in which they participated during their child's preschool and kindergarten years (1983–1986). Seventy-six percent of the sample had participated in the Child-Parent Center (CPC) program, a comprehensive language-based intervention program in the Chicago Public Schools for children living in school neighborhoods eligible for Title I funds. Children in preschool through the third grade can receive CPC services for up to 6 years (Reynolds, 1994, 1995). Parent involvement in children's education is a major goal of the program and was expected to be associated with higher school achievement and lower rates of grade retention.

Multiple regression results indicated that the frequency of parent participation in preschool and kindergarten (1 = less than monthly, 3 = weekly or more) was significantly associated with higher scores on the Iowa Test of Basic Skills (ITBS) reading achievement in kindergarten (b = 1.59; p =.032). In addition, there was a marginal association between the frequency of parent involvement and eighth grade reading achievement (b = 2.14; p =.081). When child and family characteristics were added to the model, results remained robust for kindergarten reading achievement and a marginal association remained for eighth grade reading achievement. Findings did not remain significant when program participation was included in the model. Further, the program by parent involvement interaction was not significant when added to the model.

When parent involvement was measured using an index of eight activities, the index was significantly associated with higher reading achievement. The parent involvement index was significantly associated with kindergarten reading achievement at the .004 level (b =.082). In eighth grade, the parent involvement index was associated with reading achievement at the .0001 level (b = 1.87). Even after background characteristics were included, this index of parent involvement remained significantly associated with kindergarten and eighth grade reading achievement. When specific activities were considered in the model, only volunteering in the classroom was significantly associated with kindergarten reading achievement; parents' attendance at school assemblies was significantly associated with eighth grade reading achievement.

Both the frequency and the number of activities parents were involved in were associated with lower rates of grade retention from first through eighth grade. Children of parents who reported being involved in five or more activities and involved in school on at least a weekly basis were significantly less likely to be retained in elementary school. These findings remain robust even when background characteristics are controlled.

Findings support the positive relationship between parent involvement and school performance.

Parent involvement in school does appear to have both an immediate and a long-term effect on student outcomes. These findings suggest that early intervention programs that provide family support activities may have short- and long-term effects on children. Thus, consistent with the family support hypothesis, if parents are encouraged to be active participants in their child's schooling, children ultimately benefit (Seitz, 1990). Although limited by retrospective accounts, this study indicates that the intensity of parent involvement can positively impact children's reading achievement and rate of grade retention.

References

Reynolds, A. J. (1994). Effects of a preschool plus follow-on intervention for children at risk. *Developmental Psychology*, 30, 787–804.

Reynolds, A. J. (1995). One year of preschool intervention or two? Does it matter? *Early Childhood Research Quarterly*, 10, 1–31.

Reynolds, A. J., Bezruczko, N., Mavrogenes, N. A., & Hagemann, M. (1996). *The Chicago Longitudinal Study: A study of children in the Chicago Public Schools*. User's Guide: Version 4. Unpublished.

Seitz, V. (1990). Intervention programs for impoverished children: A comparison of educational and family support models. *Annals of Child Development*, 7, 73–103.

Maintaining Home Language in Multilingual Early Childhood Programs

Patricia Clark

PRESENTER: Patricia Clark

Researchers in the field of bilingual education have ample evidence of the importance of children receiving instruction in their dominant language (Cummins, 1989; Garcia, 1993; Ramirez, Yuen & Ramey, 1991). This seems to be particularly true for young children who are at risk of losing their home language as English becomes their primary language (Wong Fillmore, 1991). For a number of years, many communities have provided bilingual early childhood programs in which the children's first language is the primary language of instruction. However, an increasingly diverse student population is making it difficult in some communities to provide this traditional form of bilingual education. This study looked at a Title VII early childhood program for children speaking languages other than English (see Clark & Bezdicek, 1994, for program description). Of particular interest was whether or not children in this multilingual setting would be able to maintain and develop their first languages.

Students' oral language proficiency in both their home language and in English was assessed upon entry to and exit from the preschool program. The assessment included a rating scale of oral language proficiency, written samples of children's language, and comments on each child's language proficiency. The rating scale, samples, and comments were completed in the child's first language by a native speaker of that language. The English language assessments were completed by the preschool teacher.

A total of 112 students were assessed when they entered the preschool program over the course of a 3-year period, from fall 1992 through spring 1995. In some cases, the language assessment was not obtained when the student left because staff were not notified ahead of time that the child would be leaving. Scores for these children were deleted, as were scores for children who were enrolled in the program for less than 3 months. This left 70 subjects with pre and posttest scores who had been enrolled in the program for at least 3 months.

Mean scores were obtained for pre and posttest assessments in the native language and in English for each child. These scores were then compared to determine whether or not the child's oral language proficiency had been maintained. Two thirds of the children (47 out of 70) had mean scores on the native language assessment that were the same or higher on the posttest, indicating that they had maintained or improved their level of oral language proficiency in their native language. Sixty-seven children out of 70 had higher mean English proficiency scores at the end of the program.

A comparison of mean scores also was done for a subgroup of students for whom the program had hired bilingual aides. The aides worked with children in the classroom in their native languages as well as with families during home visits. The same aides worked with the program over the course of the 3 years. Children in this subgroup were even more likely than the group as a whole to have mean scores on the posttest that were as high or higher than those on the pretest. Thirty-two out of the 41 children (78%) in this subgroup maintained or increased their level of language development. Only 9 children (22%) showed a decrease in mean scores from the pretest to the posttest.

Results from this study indicate that children who are enrolled in an early childhood program that emphasizes maintenance of the home language are able to maintain and develop their first language, even when the primary language of instruction is English. This is important given the diverse populations in many programs for young children. Educators, caregivers, and program administrators do not have many models to look to when trying to incorporate children's first language into a program that serves children from a variety of linguistic backgrounds. As a result, the linguistic needs of language minority children are often ignored when a

traditional bilingual program is not possible to implement. The success of this preschool program in maintaining children's first language points to the possibilities for working with language minority children in a variety of settings.

References

Clark, P., & Bezdicek, J. (1994, February). *Maintaining home language and culture in a multilingual preschool: The Multilingual/Multicultural Early Childhood Approach (MECA).* Paper presented at the annual conference of the National Association for Bilingual Education, Los Angeles, CA.

Cummins, J. (1989). *Empowering minority students.* Sacramento, CA: California Association for Bilingual Education.

Garcia, E. (1993). The education of linguistically and culturally diverse children. In B. Spodek (Ed.), *Handbook of research on the education of young children* (pp. 372–384). New York: Macmillan.

Ramirez, D., Yuen, S., & Ramey, D. (1991). *Final report: Longitudinal study of structured English immersion strategy, early-exit, and late-exit transitional bilingual education programs for language minority children (executive summary).* San Mateo, CA: Aguirre International.

Wong Fillmore, L. (1991). Language and cultural issues in the early education of language minority children. In S. Kagan (Ed.), *The care and education of America's young children: Obstacles and opportunities* (pp. 30–49). Chicago: The National Society for the Study of Education.

The Training Needs of Head Start Providers in Preventive Behavior Management

Lora Tuesday Heathfield, Susan Epps

PRESENTER: Lora Tuesday Heathfield

To adequately address the prevailing issue of increased classroom-behavior problems among young children enrolled in Head Start classrooms, a needs assessment of 39 Head Start providers in a Midwestern, urban community was conducted. Results are presented in terms of identified mental-health, service-training needs of Head Start personnel. Based on the results of the needs assessment, a three-part, in-service training program designed to enhance the skill development of Head Start providers in preventive child-behavior management techniques was developed in an effort to address their specific training needs.

(Abstract from original proposal; paper summary not available for publication.)

The Impact of Local Beliefs, Practices, and Systems on Services to Children With Disabilities in Head Start

Patricia Jessup, Sally Lubeck

PRESENTERS: Patricia Jessup, Sally Lubeck

Head Start, with its mandate to serve children with disabilities, provides an inclusive preschool option for children with disabilities. This is consistent with various legislative and policy initiatives that have been enacted over the past three decades, such as the Individuals with Disabilities Education Act (IDEA), which mandates the education of children with disabilities in the least restrictive environment. We have undertaken comparative case studies of two Head Start sites to gain an understanding of the interactions between these Head Start programs and their local special education systems and how these interactions affect the provision of services to children with disabilities.

An ethnographic approach was utilized that included: (a) observation and participation in Head Start and preschool special education classrooms, (b) interviews with Head Start and special education teachers, special education directors, and Head Start disabilities coordinators, and (c) the review of relevant documents such as the Head Start Performance Standards and state administrative guidelines for special education. The two sites included in this study varied on many dimensions. One site was a rural, but growing, affluent county that had a primarily European American population. The other site was located in an urban, African American, low-income community. In each site, the connections between the Head Start program and the special education department differed and services to children with disabilities varied. Our research focused on the interrelationship of the individual, interpersonal, and institutional characteristics that affect services to young children with disabilities within these Head Start sites, particularly in relation to the organization, and implementation of special education programs in these two locations.

Our study demonstrates how these two Head Start agencies interface with their local special education system and how local beliefs and institutional practices help to shape different outcomes for children with special needs. The community contexts, the organization and location of Head Start and special education programs, the attitudes of the special education staff, and the relationship between the special education and Head Start programs have direct and indirect impacts on services to children with disabilities in these local sites. These impacts are seen in numerous ways including how children with disabilities are referred to Head Start, the educational options that exist in each of these communities for children with disabilities, and the degree of collaboration between special education and Head Start staff.

Of particular interest has been the availability of various placement options for children with disabilities in each of these locales since a child's early educational placement in either special or general education is predictive of future educational placement. Thus, we have considered in each of these sites what influences encourage or discourage the placement of children with all types of disabilities in inclusive Head Start settings.

A Universal Newborn Hearing Screening Program: What Is Needed for Success

Gilbert R. Herer

PRESENTER: Gilbert R. Herer

International attention has focused on the earliest identification of hearing loss in babies. In 1993, the National Institutes of Health (USA) conducted a Consensus Development Conference that recommended hearing screening of all newborns preferably before hospital discharge or soon thereafter. Since then, some screening programs have begun to emerge throughout the United States.

The availability since the early 1990s of otoacoustic emissions (OAE) and screening auditory brainstem response (ABR) technologies has made a reality of cost-effective and accurate universal newborn hearing screening (UNHS) leading to the earliest detection of hearing loss. No longer should the child with a hearing loss at birth have to lose 2 to 3 vital language learning years before detection. Newborns with hearing loss can be identified and diagnosed by 3 months allowing for the onset of very early intervention strategies.

This poster session presented the protocols and ingredients of a large UNHS program as well as its successful outcomes which should encourage others to initiate and benefit from this type of worthwhile endeavor. The poster session shared experiences of the UNHS program conducted by the Children's National Medical Center (CNMC), Washington, DC, at a hospital with an annual birthing rate of 7,000. Program success depends upon a careful planning process, a very smooth start-up period, and a seamless integration of procedures into the daily routines of the hospital's mother-baby and newborn intensive care units.

The screening protocol developed by the CNMC's UNHS program yields very efficient outcomes. Ninety-eight percent of newborns pass the hearing screening before leaving the birthing hospital, requiring only 2% to return for a 1-month rescreen appointment. Data for those not passing the 1-month rescreening and subsequent ABR diagnostic testing show a hearing loss incidence rate of 2.4 per 1,000 (mild to severe in degree). This rate is quite close to population estimates for hearing loss of 3 per 1,000. Of utmost importance, however, is that essentially 2 to 3 babies of every 1,000 seen in this program had their hearing losses identified and intervention initiated before they reached 4 months of age.

The poster session handout described the components needed for a UNHS program including program rationale, quality indicators, personnel, technology, cost categories and estimates, schedules, public relations, staff training, daily sequence of activities, and other important considerations. The handout also related several interesting case vignettes of babies with significant maturational delay of the central nervous system. Based on these few cases, caution may be needed in interpreting OAE/ABR hearing screening and ABR diagnostic data as indicating hearing loss per se in babies with such conditions.

References

Glattke, T. J., Patitis, I. A., Cummiskey, C., & Herer, G. R. (1995). Identification of hearing loss in children and young adults using measures of transient evoked otoacoustic emissions. *American Journal of Audiology, 4*, 67–82.

National Institutes of Health (1993). Early identification of hearing impairment in infants and young children. *NIH Consensus Statement, 11*, 124.

Robinette, M. S. & Glattke, T. J. (Eds.) (1997). *Otoacoustic emissions: Clinical applications*. New York: Thieme.

White, K. R., Vohr, B. R., & Behrens, T. R. (1993). Universal newborn screening using transient evoked otoacoustic emissions: Results of the Rhode Island Hearing Assessment Project. *Seminars in Hearing, 14*, 18–30.

Playground Experiences of Young Children With Disabilities in a Community-Based Program

Deborah E. Carroll, Linda L. Hestenes

PRESENTER: Deborah E. Carroll

Inclusion of young children with disabilities is increasingly prevalent in community-based settings. However, much research on interactions between children with and without disabilities has been conducted in university-based programs (Siegel, 1996), restricting our understanding of community-based inclusive programs. Previous studies indicate children with disabilities may be socially isolated (Guralnik & Groom, 1988; Odom & McEvoy, 1988). Children with disabilities are less likely to be engaged in high-level interaction than are typically developing children (Hestenes & Carroll, under review). Although type of play does not appear to differ for typically developing children and children with disabilities when considering indoor and outdoor free play (Hestenes & Carroll, under review), opportunities for gross motor play are more prevalent on the playground than indoors. What factors, then, would encourage outdoor inclusive group play or high-level interaction (i.e., cooperative play, social conversation) for young children with disabilities?

Observational data from 5 preschool children (2 females) with disabilities were analyzed from playground play over a 4-week period. Children averaged 48 months in age (range: 41–56 months) and were 60% African American and 40% Caucasian. Children had been identified as developmentally delayed; 2 of the children (1 female) had severe mobility restrictions. Overall, the community-based program included 18 children (7 females), who averaged 57 months in age (range: 41–65 months) and were 77% African American, 11% Caucasian, 6% Asian-American, and 6% Hispanic. Children with disabilities were included with typically developing children during free play time each day. A total of 318 observations were collected, with an average of 64 observations per child (range: 42–87).

Variables were examined for prediction of group membership for children with disabilities in inclusive group play and in play which involved a high level of interaction. A logistic regression analysis was performed on inclusive group play as the outcome measure with four predictors: age of child, gender of child, teacher presence, and type of play (gross motor, fine motor, and other). A test of the full model with all predictors against a constant-only model was statistically reliable, 2 (5, n = 318) = 158.078, $p < .001$, indicating the predictors, as a set, reliably distinguished between inclusive group play and noninclusive group play. Gross motor play was indicative of noninclusive group play. A second logistic regression analysis was performed in which group membership in high-level interaction (i.e., cooperative activity, social conversation) was examined. High-level interaction was the outcome measure with four predictors: age of child, gender of child, teacher presence, and type of play (gross motor, fine motor, and other). A test of the full model with all predictors against a constant-only model was statistically reliable, 2 (5, n = 318) = 120.387, $p < .001$, indicating that the predictors, as a set, reliably distinguished between high-level interaction and low-level interaction (e.g., onlooking, parallel play). The presence of a teacher in the play group reliably predicted high-level interaction among children. Gross motor play predicted low-level interaction.

The Examination of Mothers Playing With Their Young Children With Visual Impairments at Home

Margaret Hughes

PRESENTER: Margaret Hughes

Over the last 3 decades in the area of visual impairment, some researchers found that mothers of blind children were more directive and controlling (Kekelis & Anderson, 1984; Imamura, 1965) and less responsive during interactions with their children (Rowland, 1984) than were mothers of sighted children. In contrast, others found mothers as responsive and positive to their children's abilities and sensory loss (Behl, Akers, Boyce, & Taylor, 1996; Bremer, 1985; Rogow, 1984). Overall, this body of literature tends to portray mothers of blind children as a homogeneous group reflecting either a positive or negative single interactional style, rather than as individuals who may vary in behavior. In order to distinguish between these two alternative viewpoints in a more contemporary light, this study examined the relation between caregiver-child interaction patterns and child competence within a sample of blind children.

Seventeen mother-child dyads from similar Anglo backgrounds with English as their primary language participated in the study. There were 10 boys and 7 girls ranging in age from 20 to 36 months. They were all legally blind with visual acuities ranging from 20/200 to no light perception (NLP). All levels of SES were represented from low- to high-income status. Data were collected in the homes, where mothers were instructed to play with their children as they normally would for approximately 15 minutes. The videotapes were coded independently by two researchers using the Parent Caregiver Involvement Scale (PCIS; Farren, Kasari, Comfort, & Jay, 1986). The PCIS is a rating scale that measures the amount, quality, and appropriateness of caregiver behaviors. The following four behaviors were analyzed: (a) directiveness, (b) control of activities, (c) responsiveness, and (d) goal setting. The Reynell-Zinkin Developmental Scales for Young Visually Handicapped Children (Reynell, 1979) were administered to each child after a play session with their mother.

In part, the findings showed that the quality of maternal control, goal setting, responsiveness, as well as appropriateness of directiveness positively related to children's receptive and expressive language development. Whereas, the amount of directiveness and amount of control negatively related to children's pragmatic language development. Additionally, other findings indicated that mothers who were high in the amount of directiveness, goal setting, and control were also high in quality of control.

It seems that mothers while playing with their children at home are exhibiting behaviors of a complex nature that are not mutually exclusive nor just positive or negative. That is, a particular aspect (i.e., quality) of a certain behavior (i.e., directiveness) appears to influence a specific development area in children, not the category of behavior itself. For example, both the quality of control and appropriateness of directive behaviors positively influenced children's language competence during play. Future research is needed to continue to identify the complex interactive factors of parental behaviors that might positively or negatively relate to the development of children with visual impairments.

References

Behl, D. D., Akers, J. F., Boyce, M. J., & Taylor, M. J. (1996). Do mothers interact differently with children who are visually impaired? *Journal of Visual Impairment & Blindness, 90*, 501–511.

Farren, D. C., Kasari, C., Comfort, M., & Jay, S. (1986). *The parent/caregiver involvement scale.* Greensboro: The University of North Carolina at Greensboro, Child Development and Family Relations, School of Human Environmental Sciences.

Imamura, S. (1965). *Mother and blind child: The influence of child-rearing practices on the behavior of*

preschool blind children. New York: American Foundation for the Blind.
Reynell, J. (1979). *The Reynell-Zinkin Scales: Developmental scales for young visually handicapped children-Part 1: Mental development.* Chicago: Stoelting Co.
Rowland, C. (1984). Preverbal communication of blind infants and their mothers. *Journal of Visual Impairment & Blindness, 78,* 297–302.

Indigenous and Informal Systems of Support for Navajo Families Who Have Children With Disabilities

Richard N. Roberts, R. Cruz Begay, Thomas Weisner, Catherine Matheson

PRESENTER: Richard N. Roberts

This paper examines the indigenous systems of support that a particular Native American culture uses to adapt to the situation of having a child with a disability. This study was undertaken in order to understand family involvement and how bureaucratic programs might work to augment informal systems.

Ethnographic interviews were conducted with 29 families on the Navajo Reservation who have a child in a bureaucratic program for early intervention for children with disabilities. We focused on how the families arranged their daily routines, with particular emphasis on how the child with disabilities is integrated into that routine. The interview and coding format followed established procedures for an ecocultural interview developed by Weisner and adapted to the Navajo culture by Begay and Roberts (Gallimore, Weisner, Kaufman, & Bernheimer, 1989; Keogh & Weisner, 1993).

Families within the study and reported here showed many of the common traits of Navajo families with children without disabilities. However, they also displayed many traits that form a common bond with families of children with disabilities from any culture in the United States. Families reported they needed to understand the disability in a way that made sense to them within the context of their cultural and ecological traditions as they developed accommodations to their daily routine based on these pressures. The common features of accommodation patterns represented by the cultural norm suggested the need for service providers to understand the cultural expectations that operate in a consistent fashion with families. At the same time, the heterogeneity of expression demonstrated that there is no universal pattern of adaptability rigorously followed by all members of a cultural group. Rather, it is a stereotype held up as a standard that families can recognize and react to, even though it may not fit their particular conditions. The adaptive patterns generated by families are, by definition, the "best fit" accommodations they are able to construct with the resources at their disposal.

1. Indigenous systems are constructed in response to enduring cultural and ecological constraints. They are sufficiently forceful that they are not easily altered without serious consequences to family well-being.
2. Bureaucratic systems will be most helpful to families when services they provide honor, respect, and support indigenous models of belief and interaction. To do otherwise creates conflict and necessitates further accommodations from families already experiencing high levels of stress.

References

Gallimore, R., Weisner, T. S., Kaufman, S. Z., & Bernheimer, L. (1989). The social construction of ecocultural niches: Family accommodation of developmentally delayed children. *American Journal on Mental Retardation, 94,* 216–230.

Keogh, B. K., & Weisner, T. (1993). An ecocultural perspective on risk and protective factors in children's development: Implications for learning disabilities. *Learning Disabilities Research and Practice, 8*, 3–10.

Table 1.
Household Composition and Type of Neighborhood for Navajo Families With Children With Disabilities

VARIABLE	NO.	PERCENTAGE
Household Composition**		
2-parent, living independently	9	31%
2-parent, living in expanded family	11	38%
single parent, living independently	3	10.3%
single parent, in expanded family	4	13.9%
Other*	2	6.8%
Neighborhood		
Camp (rural compound in which family members live near each other	19	65.6%
Navajo Housing Authority (HUD) project in "town" area	6	20.7%
Other***	4	13.7%

* Children in foster care home
** Parents in any of the above situations may also live in a compounded family or "camp," so that the independent household might be living in a family camp.
*** Trailer park, employee compound, foster home

Table 2.
Sources of Instrumental/Emotional Support: Rank Ordering of Support for Navajo Familes With Children With Special Needs (*n*=29)

SOURCE OF SUPPORT	PERCENTAGE
Church/Religious including Navajo traditional	88%
Other Family members	84%
Grandparents	64%
More than 3 sources of support	64%
Friends	12%
Professional parental therapy	8%
Other families with children like theirs	4%

Compulsive-Like Behavior in Children With Down Syndrome

David W. Evans, F. Lee Gray

PRESENTERS: David W. Evans, F. Lee Gray

The ritualistic, compulsive-like behaviors of 50 typically developing children and 50 children with Down Syndrome (DS) matched on mental age (MA) were examined, and the adaptive/maladaptive correlates of such behaviors were explored. In line with the similar sequence/similar structure approach to mental retardation, children with DS engaged in similar levels of repetitive, compulsive-like behaviors compared to their MA-matched controls. Correlations between compulsive-like behaviors and adaptive/maladaptive behaviors suggest that this aspect of child behavior may serve differing functions for children with and without DS. Results are discussed for their implications for developmental theory, as well as possible avenues for intervention.

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Serving Young Children With Emotional and Behavioral Challenges in Early Childhood Programs: Policy and Research Issues

Maureen A. Conroy, William H. Brown, Wesley Brown

PRESENTERS: Maureen A. Conroy, William H. Brown

Today, many young children demonstrate challenging and inappropriate behaviors that interfere with their ability to develop and learn. Although all of these children are not always specifically identified or labeled as having an emotional/behavioral disorder, behavior disorders have been identified as the second most suspected disability for children between birth and 5 years old (Bennett & DeLuca, 1995). Behavior disorders occur frequently in young children, with 15–25% of these children demonstrating mild behavior problems and 7% demonstrating moderate to severe behavior problems (Webster-Stratton, 1993). These young children initially receive a variety of services in early childhood settings such as Head Start programs and community child care centers. However, due to the nature of their severe behavior problems, they are often later placed in segregated early intervention programs (e.g., therapeutic mental health centers or self-contained special education programs).

Since the passage of P.L. 99-457 in 1986, services for young children who demonstrate developmental disabilities have expanded. According to Zabel (1991), these services should emphasize collaboration, prevention, and family-centered practices. Although services for young children with identified developmental disabilities (e.g., mental retardation) have been expanded considerably over the past decade, this expansion has not necessarily included services to address the needs of young children with behavior disorders. Young children who demonstrate behavior disorders often "fall through the cracks" of the present day early intervention service delivery system and may not receive the appropriate services that address their behavioral needs until they are of school age. It appears that this gap in the service delivery system occurs for several reasons.

The primary barrier that overall interferes with appropriate services for young children who demonstrate behavior disorders is the lack of systemic, collaborative policies and procedures that identify and provide appropriate services for these children at an early age (Conroy, Brown, & Fox, 1996). Within this overall barrier lie two significant programmatic obstacles: (a) the lack of an appropriate identification system, and (b) the lack of implementation of appropriate

intervention techniques. This paper presents a two-level model service delivery system that addresses policy, identification, and intervention barriers. The first level is a prevention level that focuses on the development of future policies that are collaborative, comprehensive, and address the need to appropriately identify and provide services to these children at an early age. This level includes the development of policies that are preventive and the implementation of proactive strategies that target children who are high risk for the development of behavior disorders and provide preventive support to these children, their families, and their teachers in inclusive community settings. The second level is a remediation level that implements a functional identification system as well as a collaborative intervention component that provides comprehensive positive behavioral supports to these children, their families, and their teachers in inclusive community settings. The outcomes of this model are threefold: (a) the development of systemic policies and practices to prevent behavior disorders in young children, (b) the early identification and remediation of behavior disorders in young children, and (c) the provision of positive supports to children's families and teachers in inclusive community agencies.

References

Bennett. T., & DeLuca, D. (1995). *1995 Needs assessment report (Head Start Region V).* Champaign, IL: Great Lakes Resource Access Project.

Conroy, M., Fox, J., & Brown, W. (1996). *Promoting inclusive services for young children at risk for emotional/behavioral disorders: Moving from policy to practice.* Paper presented at the DEC Early Childhood Conference on Children with Special Needs, Phoenix, AZ.

Webster-Stratton, C. (1993). Randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology, 57,* 666–678.

Zabel, M. K. (1991). *Teaching young children with behavioral disorders.* Reston, VA: Council for Exceptional Children.

Meeting the Needs of Children With Disabilities in Child Care: Practical Challenges and Implications for Ongoing Research

Susan L. Recchia, Yumiko Sekino, Adora Angeles-Bautista, Yoon-Joo Lee

PRESENTERS: Adora Angeles-Bautista, Yoon-Joo Lee, Yumiko Sekino

The purpose of this study was to explore the experiences of three toddlers with special needs, their families, and their caregivers in an inclusive infant-toddler child care center. These children were part of a larger study examining the ways new caregivers form relationships with toddlers in their care. Similarities and differences between the children with special needs and their typical peers were examined with regard to: (a) initial parent anxiety, (b) caregiver perceptions of their relationships with the children, and (c) the development of secure attachments with caregivers over time. Case portraits of three toddlers with special needs are presented to provide a closer look at specific caregiving needs and challenges for families and caregivers and the nature of the interactions between these children and their typical peers within the child care setting.

Data from the larger study focused on 11 children, their mothers and fathers, and 11 caregivers. The children ranged in age at the start of the study between 10 and 28 months. Caregivers were female graduate students participating as new training fellows at the center. Each student caregiver was assigned a study infant or toddler as their "key child." Parental anxiety was assessed as families entered the program. Children's behavioral responses toward their caregivers

were assessed at two time points using the Waters Attachment Q-Set (1987). Caregivers were asked to rate their perceptions of their relationships with the study children using the Pianta Student Teacher Relationship Scale (1996). Videotapes of the three profiled children with special needs were coded for child and peer initiations and responses, level of social exchanges between peers, and caregiver interactions with the children and their peers.

Findings of interest include the following:

1. Parents of children with special needs had specific concerns about their children entering child care. Establishing and maintaining open communication with these families was important to both parents and caregivers. Results from the Parental Anxiety Scale (Hock, McBride, & Gnesda, 1989) suggest that fathers of children with special needs may have higher levels of anxiety than fathers of typical children entering child care.
2. Caregivers of children with special needs expressed concerns about their ability to adequately meet both the needs of children and the expectations of parents. They developed perceptions of closeness to their key children that were more powerful than those of the other caregivers.
3. Children's attachment behavior toward caregivers showed only one significant between-group difference—dependency behavior at Time 1. Children with special needs showed higher levels of dependency on adults even before they knew them. When changes in the level of observed security and dependency were examined within groups, however, a more dramatic result emerged. Typical children showed highly significant changes over time in both security and dependency with their key caregivers, while children with special needs showed no significant differences between these measures at the two time points.
4. Qualitative descriptions of the social interactions of children with special needs indicate limited levels of social exchange and expression. Caregivers may need to take greater responsibility in facilitating play for these children.

References

Hock, E., McBride, S., & Gnezda, M. T. (1989). Maternal separation anxiety: Mother-infant separation from the maternal perspective. *Child Development, 60*(4), 793–802.

Pianta, R. C. (1996). *The Student-Teacher Relationship Scale.* Unpublished manual, University of Virginia, Charlottesville.

Waters, E. (1987). *Attachment Behavior Q-Set* (Revision 3.0). Unpublished instrument, State University of New York at Stony Brook.

Influences of Training, Experience, Disability, and Context on Caregivers' Attitudes Toward Including Children With Special Needs in Canadian Child Care Programs

Donna S. Lero, Sharon Hope Irwin, Kathleen Brophy

PRESENTERS: Donna S. Lero, Sharon Hope Irwin

An opportunity to compare the Canadian voluntary approach to inclusion of children with special needs with the mandated United States approach is presented. How training, experience, disability, policy, and context enable or frustrate efforts to include children with special needs in Canadian child care programs is explored.

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Familial and Cultural Contributions to Social Interaction, Self-Determination, and Language in Young Latino Children in an Early Head Start Program

Joseph J. Stowitschek, James Rodriguez

PRESENTERS: Joseph J. Stowitschek, Eduardo J. Armijo

The results of a comprehensive, training approach for Head Start teachers working with children with special needs are presented. One of five participating programs is presented as an illustrative example. Graphic representations of the results are displayed and explained. Implications for Head Start staff development are discussed.

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Fathers

Early Language and Academic Development in Deaf Children: Families With and Without Fathers

Rosemary Calderon, Sabina Low

PRESENTER: Rose Calderon

Interest in the role of the father in normal children's development has steadily increased over the past 20 years. Despite these gains, literature on fathers is lagging outside of the context of normal child development. Most of the research over the past 20 years involving parents of special-needs children has focused on adaptation and marital satisfaction from the mother's perspective. Research focusing solely on fathers of disabled children yields inconsistent findings. Some studies indicate an increase in care shown by fathers to their children with disabilities and other studies report no differences. Literature on parenting children with a specific chronic disability, such as deafness, is wanting, and research on fathers of deaf children is even more so. This paper addresses the question: Are there differences in outcomes between children whose fathers were continuously present in the study and those who did not have a father? This question reflects the emphasis of this study on appreciating the impact that family factors can have on a child's academic and language outcomes.

Participants were 22 children with sensorineural hearing loss ranging from prelingual to moderately-severe to profound who graduated from an early intervention program and were born between 7/01/89 and 11/30/92. Of the 22 subjects who completed the study, 17 had fathers who were present for both the early intervention and follow-up component of the study. Five subjects did not have a father present for either the early intervention or the follow-up. This study compared children's language at the time of graduation from early intervention (36 months) and language and early academic skills at follow-up (9 to 47 months postintervention) as a function of father status (present or absent throughout). Measures included the SKI*HI Language Development Scale score at exit from early intervention, and the Test of Early Reading Ability-Deaf/Hard of Hearing (TERA), the Preschool Language Scale-3 (PLS), and the teacher and parent-rated Language Proficiency Profile (LPP) at follow-up.

T tests and Mann-Whitney U tests for independent samples were conducted in order to determine whether the two groups differed on the academic and language outcomes. Results indicate that children with a father consistently present demonstrated stronger language and academic skills than those without a father present.

These findings suggest several possibilities: (a) children benefit from greater exposure to language and communication stimuli provided by a father's presence; (b) fathers provide another consistent adult which necessitates more frequent communication attempts by the child; or (c) fathers present children with play interactions that encourage nonverbal but essential communication behaviors. These findings have implications for designing early intervention programs and highlight the importance of family-centered intervention programs that accommodate both caregivers if available.

Relational and Task-Oriented Interpretations of Engaged Fathering

Mark Langager, Sarah Shaw

PRESENTER: Mark Langager

The impact of fathering on children's development enjoys less consensus than mothering (Day, Evans, & Lamb 1997). In an evaluative study of Early Head Start (EHS) programs, parents—generally mothers—interviewed and observed interacting with their children were used as major data sources regarding the impact of EHS interventions. More recently, fathers began being interviewed and observed to investigate ways in which EHS' impact on fathers may show up in changes in child functioning (Mathematica Policy Research, Inc., November 1996). This paper addresses the need to differentiate between interpretations of "engaged fathering" when discussing father involvement with various stakeholders in EHS programs.

In an exploration of fathers' roles from a variety of perspectives, two visits were made to a local EHS site in January and July, 1997. During the first visit, a preliminary investigation was conducted among fathers of EHS children and staff at the EHS center. During the second visit, three focus groups were conducted: one with fathers, one with mothers, and one with program staff. We asked questions to elicit the respective focus group members' views of fathering, the importance of father involvement for children, and the role of EHS in supporting fathers.

The attitude that this local EHS program aspires to project to fathers is, "You are important not just as a breadwinner, but as a parent." We ask: "What does parenting entail for fathers, other than breadwinning?" An answer which emerged from these interviews and focus groups is that there is a traditional set of fathers' roles, which tends to limit paternal activities to a structured domain, as well as a more "engaged" set of roles, in which fathers take a more active, less structured part in parenting.

In a traditional understanding of fathering, a father attends certain church and school-related functions and so forth, and accompanies the child to the store or the park upon the mother's request. His tasks tend to be well defined before each event begins. The time required is predictable and limited. Another characteristic is his severe discipline and his periodic use of physical punishment. Descriptions of the "traditional father" show him as emotionally distant, but stable and dependable.

In discussions about a more engaged set of fathers' roles, two themes emerged with relatively recurring distributions: relational involvement and task-oriented involvement. In our discussions with men, the image of an engaged father evoked such concepts as sensitivity and vulnerability and such activities as teaching, motivating, and a less severe form of discipline. In discussions with women, on the other hand, there seemed to be a tendency to define the "engaged father" more in terms of his participation in the mundane tasks of child care, such as feeding and diapering.

In future research on various stakeholders' perceptions of father involvement, more attention should be paid to the specific ways in which "engaged fathering" (as opposed to "traditional fathering") is interpreted. Our sense is that it will tend to be framed either in relational terms or in task-oriented terms.

References

Day, R. D., Evans, J., & Lamb, M. (co-Chairs). Working Group on Conceptualizing Male Parenting. (1997). *Social fatherhood and paternal involvement: Conceptual, data, and policymaking issues.* Presented at the NICHD-sponsored Conference on Fathering and Male Fertility: Improving Data and Research, March 13–14, 1997.

Mathmatica Policy Research Inc. (1996). *Studies of father and male involvement in early Head Start families and programs: Plans and prospects for an integrated program of research.* Princeton, NJ: Mathmatica Policy Research.

Fathers and Families: Working-Class, Mexican-Origin Fathers' Parenting Strategies

Harriett Romo, Nelda Lopez, Joy Phillips, Maria de la Piedra, Jo Ann Salas, Archie Wortham

PRESENTERS: Harriett Romo, Nelda Lopez, Joy Phillips, Maria de la Piedra, Jo Ann Salas, Archie Wortham

Mexican-origin fathers' social constructions of their roles in the education of their children are discussed. Data from a team research project using questionnaires, interviews, and focus groups, along with fathers' life stories about their experiences with schooling are presented. Mothers' reflections on the roles of fathers and their experiences when fathers are absent are also included. The study concludes with suggestions to educational programs to help increase the involvement of fathers.

Stereotypes of Mexican-origin families persist despite the fact that these families value education and struggle with the same social and economic pressures facing families of other ethnic backgrounds (Mirande, 1988; Williams, 1990). Teen parenthood, immigration, and extended family relationships all shaped fatherhood for these families. Teen parents experienced ambivalence in their roles as adolescents and parents (Feldman and Elliott, 1990). Most teen fathers interviewed still lived with their own parents, not with their child or the child's mother. They recognized that becoming a father meant a change in lifestyle and assuming adult responsibilities; they could no longer "hang out" with friends. They resented stereotypes of teenagers as lazy, uncaring, absent, or insensitive fathers. The teen mother's parents could be an obstacle or a solidifying element in helping the teens learn to be parents. Grandparents' acceptance of the pregnancy facilitated teen fathers' active involvement with their children.

Family patterns and women's and men's roles also changed as a result of immigration and urbanization (Hondagneu-Sotelo, 1994). Immigrant fathers were perceived as the provider and the "head of household" who guaranteed the survival of the family. Immigrant fathers participated in the education of their children by teaching good manners, morals, and right from wrong. The father was considered the advisor and example for his children. Fathers taught their children relationships of *confianza* (mutual trust) and *respeto* (respect) (see also Valdés, 1996). The process of immigration often contributed to the breakdown of family relationships because of fathers' extended absences from families (McLanahan & Sandefur, 1994; Popenoe, 1996). When fathers were absent, mothers often assumed the double role of mother and father. "Moms as dads" became providers, nurturers, teachers, and disciplinarians. Mothers with higher levels of literacy and work skills, often on the brink of self-sufficiency, experienced greater depression than mothers with few skills and lower levels of education. Interviews suggested that these mothers struggled with issues of poverty, isolation, and the stress of raising small children while they worked or attended school.

Fathers and mothers indicated that they would not be the same type of parent as their own parents. These fathers were interested in being involved in the education of their children, but their perceptions of involvement differed from traditional definitions of involvement that included volunteering at school, attending meetings, and teaching children academic skills (Delgado-Gaitan, 1990; U.S. Department of Education, 1994). The fathers wanted to be emotionally involved with their children, but they also believed that a "good" father was a hard worker and the main financial provider for his children. Mothers often felt that wage-earning fathers were "there but not there." Higher incomes provided greater access to resources, but it was difficult for fathers to reclaim fatherhood when their work did not allow them to spend time with their children. Families wanted parenting programs that fostered the parents' goals for their children, not programs aimed at changing families (Velez-Ibañez, 1992). Understanding families' different perceptions of fatherhood can help educational program directors provide a foundation for support among parents. The fathers interviewed believed that programs like Early

Head Start could provide information and assistance to help them be better fathers.

References

Delgado-Gaitan, C. (1990). *Literacy for empowerment: The role of parents in their children's education.* London: Falmer.

Feldman, S. S., & Elliott, G. R. (1990). *At the threshold: The developing adolescent.* Cambridge, MA: Harvard University Press.

Hondagneu-Sotelo, P. (1994). *Gendered transitions: Mexican experiences of immigration.* Berkeley: University of California Press.

McLanahan, S., & Sandefur. G. (1994). *Growing up with a single parent: What hurts, what helps.* Cambridge, MA: Harvard University Press. ED 375 224.

Mirande, A. (1988). Chicano fathers: Traditional perceptions and current realities. In P. Bronstein & C. Cowan, (Eds.), *Fatherhood Today,* (pp. 93–106). New York: Wiley.

Popenoe, D. (1996). *Life without father.* New York: Martin Kessler Books.

US Department of Education. (1994). *Strong families, strong schools: Building community partnerships for learning.* Washington, DC: US Department of Education. ED 371 909.

Valdés, G. (1996). *Con respeto: Bridging the distances between culturally diverse families and schools.* New York: Teachers' College Press.

Velez-Ibañez, C., & Greenberg, J. (1992). Formation and transformation of funds of knowledge among US-Mexican households. *Anthropology and Education Quarterly, 23*(4) 313–335.

Williams, N. (1990). *The Mexican American family: Tradition and change.* New York: General Hall, Inc.

The Negotiation of Parental Roles: Fathers Whose Babies Are Born to Low-Income, Adolescent Mothers

Lorrie Gavin, Margaret Bentley, Maureen Black, Laureen Teti

PRESENTER: Lorrie Gavin

Qualitative interviews were conducted among adolescent mothers, fathers, and maternal grandmothers in 18 low-income, urban households. Beyond financial support, mothers and grandmothers looked to fathers for child care, whereas fathers saw their role as formation of the child's character. When expectations were not met, mothers and grandmothers often restricted the father's access to the baby.

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Second Cup of Coffee: Fathers' Involvement in an Urban Chicago School

David Campos

PRESENTER: David Campos

Second Cup of Coffee is a parent organization at a culturally diverse elementary school in urban Chicago. Parents gather on Thursday mornings for a second cup of coffee and the opportunity to work with their child in designated activities. Fathers of Second Cup of Coffee were interviewed to determine whether they are aware of the impact they have on their sons' education, and whether there is a performance difference between boys whose fathers participate in the program and those who do not. Results are discussed.

Health

Direct Service Sealant Project Using Public Health Dental Clinics and a Mobile Dental Trailer

Perminder Wadhwa

PRESENTER: Perminder Wadhwa

The Direct Service Sealant Project using public health dental clinics and mobile dental trailers was designed to provide free sealants to second grade students in target public schools of Broward County.

The National Health Objective for year 2000 as established by the U.S. Public Health Service states that 50% of 8- and 14-year-old children should have pit and fissure sealants on one or more molar teeth (U.S. Department of Health & Human Services, Public Health Services, 1990). In 1986, about 11% of 8-year-olds and 8% of 14-year-olds were found to have sealants. Researchers found that during 1988 to 1991, about 18.5% of US children and youth ages 5 to 17 had one or more sealed permanent teeth (Selwitz, Winn, Kingman, & Zion, 1996). This is double the percentage of children with sealants in the previous national survey (7.6% in 1986–87). Despite the increase in sealant prevalence, fewer than one in five US children and adolescents ages 5 to 17 years had one or more sealed permanent teeth (American Dental Association Report on Dental Sealants, 1997). Although there is some indication that use of sealants has increased, there remains a significant gap between current prevalence and the year 2000 objectives.

Community programs for sealants are most often either school based or school linked and designed to meet community needs. Communities vary with respect to caries prevalence, treatment resources, public health systems, and the value placed on oral health and caries prevention.

This agency/community-based project was designed to provide dental sealants to second grade students of target schools based on the highest percentage of indigent children as defined by the School Board's free and reduced school lunch program. Dental sealants were provided either onsite (at school) in a mobile dental trailer or by transporting children from area schools in Head Start transportation to the Broward County Health Department (BCHD) Dental Clinics. The second purpose of this project was to compare the costs of providing these services.
In designing a direct service community sealant program, the following factors need to be considered.

First, one must define the community. The Broward County Health Department dental section had identified second grade students of target public schools as the "community" who would receive sealants. The children were from low-income families.

Second, one must assess the community need for dental sealants. Verification can be done by an epidemiological survey or needs-assessment study or informally by observation made by dental clinic staff. Various studies have shown that less than 19% of children have one or more sealants on their teeth (Selwitz, et al., 1996). This data is applicable to selected target schools in this project.

Third, one must weigh support and constraints for Sealant Program development. Once the need has been established, it is necessary to identify support and constraints which may influ-

ence the project. This project was supported by Health Department funds. The BCHD had access to a semi-trailer available from the local Kiwanis Club. The trailer was modified to function as a dental office with portable dental equipment. The equipment is placed in the trailer when needed by the dental team, comprised of a dentist, dental assistant, and a dental hygienist.

Constraints that restrict this project include the State's Dental Practice Act, which requires that sealant application by a dental assistant is done only under the direct supervision of a licensed dentist, who must be present on the premises. Therefore, due to limitation of space, only the dentist provides sealants. This increases cost per session due to a higher hourly salary for the dentist. A second constraint is that the Broward County Schools have been mandated to have a 2-hour reading period for all grades so some teachers are reluctant to allow students to miss school time for dental services.

Fourth, one must select an approach for increasing sealant prevalence. Two delivery systems for providing direct services were tested. As stated earlier, the dental hygienist assigned to the school would coordinate sealants for second grade classes. After the dental exam on the trailer, students could receive sealants on the same or subsequent day. The second method was to transport students from target schools to the nearest Public Health dental clinic using Head Start transportation. The Broward County Health Department contracts with Head Start to provide dental services. Students are transported to clinics for care. The second grade students participating in the dental sealant program would ride the bus with the Head Start students. After the exam, one dental assistant provides sealants while another assistant helps the dentist with routine care of other patients. This is a cost-effective way of providing sealants.

Fifth, the specific population should be defined. Second-graders from four schools were selected for this project. The Kiwanis Trailer project included 323 second grade students, while 243 students from the Cluster School Project were selected for transportation along with Head Start students who were to be treated at the clinic. Sealants were provided free of cost.

Sixth, individuals must be identified to be evaluated for sealants. A total of 566 students were included in this study. Of these, 323 were examined in the trailer or school classroom and 243 were selected for Cluster Schools Sealant Project and transported to dental clinics for an exam and follow-up. Overall, 477 students from two groups received sealants or 84.7% were completed with an average of 3.6 sealed teeth per patient. Approximately 15.7% or 89 students did not qualify for sealants after the exam due to unerupted molar teeth or extensive decay.

Finally, periodic evaluation and effectiveness of the program should include program quality, cost, and whether it continues to meet the needs of the community. Another evaluation component should include data on sealant retention.

Program efficiency can be measured in terms of cost per individual, per tooth sealed, or per number of caries lesions prevented. Cost analysis, comparing the Cluster Schools Sealant Project with the cost of providing sealants on the school campus, showed that the average cost per sealant was $5.08 in the clinic versus $6.97 per sealant in the trailer, a difference of $1.89 per sealed tooth or 27.11% higher on the trailer. Head Start transportation is federally funded so Broward County did not incur any expense for this part of the project. While the second grade students are being treated by the dental assistant in the dental clinic, the dentist provides dental care to Head Start children. This results in effective utilization of the dentist's time and generates revenue for the Health Department. By locating the trailer on the campus of a target school, the dental team is able to see 16 patients each session at a slightly higher cost per sealed tooth. The Broward County Health Department is committed to paying for the operating costs incurred by the trailer. The trailer makes it convenient for students who spend a minimum time out of class for sealant application. Both delivery systems are effective and achieve program objectives.

Cost analysis shows that it is less expensive to have students come to the clinic for dental service. As Head Start is a federally funded program, it has a higher probability of continued funding in future. Thus, transportation for the second grade students may continue to be available so long as all individuals are willing to participate. While use of the trailer meets the program needs, it is not as cost effective.

Dentists are required by Florida Statute 466.004 (4) Chapter 59Q - 16.001 to provide direct supervision when a remediable task is performed by a dental assistant. Eighteen other states have similar laws. Remaining states permit sealant application by certified dental assistants under general supervision (American Dental Hygienist Association, 1995). A change in Florida law that would enable certified dental assistants to perform remediable tasks under general supervision would significantly benefit public health.

References

American Dental Association Report on Dental Sealants. (1997). *Journal of the American Dental Association, 128,* 485-488.

American Dental Hygienist Association. (1995). *Permitted functions and supervision levels by state. Florida Statute 466.004(4), 16,* p. 1293, Chapter 592 - 16.001.

Selwitz, R. H., Winn, D. M., Kingman, A., & Zion, G. R. (1996). The Prevalence of Dental Sealants in the U.S. Population: Findings from NHANES III, 1988-91. *Journal of Dental Research 75,* Special Issue, 652-660.

U.S. Department of Health and Human Services, Public Health Services. (1990). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Washington, DC: U.S. Government Printing Office.

Productivity Enhancement Project: Mobile Dental Sealant Project (1996). Broward County Health Department.

Workshop on Guidelines for Sealant Use: Recommendations (1995). *Journal of Pubic Health Dentistry,* 55, 263-273.

Oral Liquid Medications: Implications for Dental Caries

Nancy Dougherty, Maureen Romer, Rebekah Tannen

PRESENTERS: Nancy Dougherty, Rebekah Tannen

The public has long recognized the potential of sugary foods, such as candy, cake, and soft drinks to cause dental caries. However, a frequently overlooked source of fermentable carbohydrates that may be implicated in dental decay is children's oral liquid medications. Several studies have shown that sugar-containing liquid medications can be causative factors in dental caries (Roberts & Roberts, 1979; Greenwood, Feigal, & Messer, 1993).

These issues have been addressed in the British dental and pharmaceutical literature, resulting in a movement toward the development of sugar-free medications in that country. In contrast, very little information about the cariogenic potential of sugared medications can be found in American literature.

We conducted a pilot survey of pediatricians at a major academic center to gauge their awareness and consideration of the sugar content of oral liquid medications. In our study, the vast majority of pediatricians were aware of sugar as an inactive ingredient in children's medications. However, only slightly more than half perceived it as a risk to dental health. Even fewer (26%) acknowledged that they made parents aware of the cariogenic potential of the medications prescribed for their children.

A British study of general practitioners confirmed our own findings (Bentley & Mackie, 1993). Most of the physicians surveyed felt that sugar in medications was not an important issue, especially when viewed in context with other sources of fermentable carbohydrates in the daily diet. They felt that this was especially true for children who are generally in good health and require medications on an infrequent basis for brief illnesses. However, how infrequent is

the use of medication, even in children without chronic medical conditions? A 1980 study established that, on any given day, approximately 17% of children were taking a cough preparation (Mackie & Hobson, 1993). Another paper provided evidence that many children between the ages of 3 and 11 years are on medications, either prescribed or over-the-counter, for an average of 1 week in 8 (Rylance & Woods, 1988).

Children with chronic medical conditions requiring long-term use of liquid medications have been shown to be at even greater risk for dental caries than the general pediatric population (Hobson, 1980; Feigal & Jensen, 1982). One study demonstrated that some children with cardiac conditions were ingesting as much as 46 grams of sugar a day solely from their medications (Kenny & Somaya, 1989). Iatrogenically imposed dental decay may be especially burdensome for children with developmental and medical disabilities who may have difficulty obtaining adequate dental care.

We feel that increasing physicians' and the public's knowledge of the potential harmful oral side-effect of sugar-based medications may spur an increase in the demand for sugar-free liquid medications. Children's medications should have a full list of constituent ingredients including the grams of sugar per dose unit. At the very least, lists of sugar-free medications should be readily available to physicians and the public. We would hope that a better informed public may encourage the pharmaceutical industry to develop palatable sugar-free medications, either in liquid or chewable tablet form.

References

Bentley, E. M., & Mackie, I. C. (1993). A qualitative investigation into general practitioners' views on prescribing sugar-free medicines for children prior to a dental health education campaign. *Health Education Research, 8*(4), 519–524.

Feigal, R. J., & Jensen, M. E. (1982). The cariogenic potential of liquid medications: a concern for the handicapped patient. *Special Care in Dentistry, 2*, 20–24.

Greenwood, M. E., Feigel, R. J., & Messer, H. (1984). Cariogenic potential of liquid medications in rats. *Caries Research, 18*, 447–449.

Hobson, P. (1980a). The treatment of medically handicapped children. *International Dental Journal, 30*, 141–158.

Kenny, D. J., & Somaya, P. (1989). Sugar load of oral liquid medications on chronically ill children. *Journal of the Canadian Dental Association 55*(1), 43–46.

Mackie, I. C., & Hobson P. (1993). Factors affecting the availability of sugar-free medicines for children—a survey in the UK. *International Journal of Pediatric Dentistry, 3*, 163–167.

Roberts, I. F., Roberts, G. H. (1979). Relation between medicines sweetened with sucrose and dental disease. *British Medical Journal, 2*, 14–16.

Rylance, G. W., & Woods, C. G. (1988). Use of drugs by children. *British Medical Journal, 297*, 445–447.

Growth Delay and Feeding Disorders in Children Participating in a Neonatal Intensive Care Follow-up Clinic

Suzanne H. Michel, Judith Silver, Jeanette Pleasure

PRESENTER: Suzanne H. Michel

Optimal growth and development are dependent on adequate nutrient intake. Growth problems and failure to thrive are estimated to affect 10% of the pediatric population. Pediatric undernutrition results from multiple factors including medical, physical, behavioral, and social. Often several of these factors interact, further complicating the diagnostic and intervention issues. The

ability of young children to benefit from the education programs provided by Early Head Start and Head Start is directly related to a child's past nutrition history and current nutrition status. Historically, Head Start has addressed the nutrition needs of children. Its programs support optimal nutrient intake and positive eating behavior. Many children eligible for Head Start have histories of significant medical and social risk factors associated with undernutrition. A significant portion were preterm infants and were hospitalized in neonatal intensive care units (NICU).

The purpose of this study was to document the prevalence of growth delay and feeding disorders in a sample of children participating in a multidisciplinary pediatric developmental clinic for infants and children discharged from an urban NICU. A consecutive series of patients (34) were evaluated for growth, feeding difficulties, nutrient intake, medical and social complications, and developmental delay. Data were entered into a computerized data base.

The group included 27 boys (79%) and 7 girls (21%). The average length of gestation was 30.9 ± 3.5 weeks. Mean chronological and adjusted ages were 20.5 ± 2.5 months and 18.3 ± 6 months, respectively. When comparing weight to height on standardized percentile curves, 44% of the sample was at or below the 10th percentile and 32% of the sample was at the 25th percentile. Only 13% of the sample was at the 50th percentile and 11% were at, or above, the 75th percentile. Based on multidisciplinary developmental evaluations, 74% were referred for early intervention services (EI). Among those referred for EI, 15% were diagnosed with cerebral palsy, 24% with developmental delay, 35% had feeding difficulties, and 75% had a medical diagnosis impacting on nutrition status. Ninety-four percent of the sample qualified for the WIC supplemental food program, yet only 71% were enrolled; 93% were eligible for food stamps and 90% were enrolled. Overall, prevalence of nutrition risk in this group of children was 94%. Level of nutrition risk ranged from no risk in 6%, mild in 35%, moderate in 24%, and severe in 35%.

The results of this study indicated that: (a) enrollment in a comprehensive, multidisciplinary NICU follow-up program and funded supplemental food programs does not guarantee that nutrition risk is adequately minimized, (b) there is a clear role for the registered dietitian in NICU follow-up programs, and (c) to improve nutrition outcome and optimize growth and development in this high-risk population of children, partnerships among hospital and community-based registered dietitians, EI/Head Start programs, community health programs, community nutrition programs, and the children's families are essential.

References

Bayerl, C. T., & Ries, J. D. *Early Start: Nutrition services in early intervention*. Office of Nutrition, Bureau of Family and Community Health, Massachusetts Department of Public Health and Department of Nutrition, The Eunice Kennedy Shriver Center-University Affiliated Program.

Bayerl, C. T., Tiew, J. D., Bettencourt, M. F., & Fisher, P. (1993) Nutrition issues of children in early intervention programs: Primary team approach. *Sem Pediatric Gastroenterol Nutrition, 4*, 11–15.

Casey, P. H., Kraemer, H. C., Bernbaum, J., Tyson, J. E., Sells, J. C., Yogman, M. W., & Bauer, C. R. (1990). Growth patterns of low birth weight preterm infants: A longitudinal analysis of a large, varied sample. *Journal of Pediatrics, 117*, 298–307.

Hack, M., Merkatz, I. R., McGrath, S. K., Jones, P. K., & Fanaroff, A. A. (1984). Catch-up growth in very low birth weight infants, clinical correlates. American Journal of Diseases of Children, 138, 370–375.

Hine, R. J., Cloud, H. H., Carithers, T., Hickey, C., & Hinton, A. W. (1989) Early nutrition intervention services for children with special health care needs. *Journal of the American Dietetic Association, 89*, 1636–1639.

Position of The American Dietetic Association (1995). Nutrition services for children with special health needs. *Journal of the American Dietetic Association, 95*, 809–812.

Yadrick, K., & Sneed, J. (1994). Nutrition services for children with developmental disabilities and chronic illnesses in education programs. *Journal of the American Dietetic Association, 94*, 1122–1128.

Child and Family Ecological Factors Influencing Use of a Regular Source of Health Care for Former Head Start Children

Martha M. Phillips, Robin Gaines Lanzi

PRESENTER: Robin Gaines Lanzi

It is generally recognized that the health of children is best served when the care they receive is continuous and comprehensive (St. Peter, Newacheck, & Halfon, 1992). The ability of a given family to avail themselves of consistent care, however, may be influenced by legal, geographic, institutional, systemic, or personal barriers (Klerman, 1992). Removal of such barriers to consistent care is the focus of current state and national movements to reform systems of health care provision and coverage, particularly as those systems relate to children's health.

Data collected as part of the National Head Start/Public School Early Childhood Transition

Table 1.

Family Circumstance, Child Health, and Financial Characteristics (in percentages) of Families With and Without Regular Place for Health Care (regular versus irregular care)

ITEM	REGULAR PLACE FOR CARE	NO REGULAR PLACE FOR CARE	P-VALUE
Children's health			
Child's health poor	4.8	8.8	0.022
Child's activities limited by health problems	6.5	3.8	NS
School attendance limited by health conditions	2.2	1.3	NS
Number of Illnesses (M, SD)	2.8, 2.6	1.6, 2.0	0.0001
Family circumstances			
Number of children in family (M, SD)	2.8, 1.4	2.9, 1.6	NS
Number of adults in family (M, SD)	1.9, 0.9	2.0, 0.8	NS
Family size (M, SD)	4.7	4.9	NS
Language other than English spoken in home	13.1	40.1	0.001
Single household parent	58.6	41.4	0.001
Another adult helps care for the child	69.0	69.2	NS
Grandmother helps care for the child	23.7	21.1	NS
Homeless within past year	2.8	5.1	0.108
Currently employed	45.3	59.1	0.001
Caregiver has chronic health problem	3.6	2.5	NS
Family moved two or more times in past year	7.0	7.0	NS
Caregiver has less than high school	32.5	34.0	NS
Caregiver is immigrant (moved to US within 10 years)	8.3	27.0	0.001
Financial circumstances			
Income less than $24,000 annually	9.6	8.3	NS
Type of insurance			
Medicaid/Medicare	56.6	37.1	0.001
Insurance/employer	22.7	19.5	NS
Insurance/individual	1.9	1.3	NS
Not covered	10.9	40.3	0.001
Other	8.0	1.9	0.005

Demonstration Study—a longitudinal, 30-site study of former Head Start children and their families spanning K-3—indicates that 95% of the 3,065 former Head Start families had a regular place through which health care was sought. Especially intriguing was the 5% of the families who reported that no consistent health care facility was used. It was hypothesized that this "irregular care" group would evidence distinctive family, child, and financial characteristics, compared to those families who use a regular source of health care (the "regular care" group).

Information was obtained in kindergarten. Variables investigated included: (a) consistency of care, (b) child health, (c) family circumstances, and (d) financial resources. Univariate and multivariate analyses were completed.

Table 1 summarizes the results of univariate analyses. In terms of children's health, children in the "irregular care" group tended to be less healthy than those with a regular source of health care, being judged by their families to be in generally poor health (9% versus 5%, p=0.022). However, families with irregular care reported fewer illnesses or injuries requiring medical attention within the past year (mean of 1.6 versus 2.8, p=0.001) and speak a language other than English in the home (40% versus 13%, p=0.001), suggesting barriers of language and familiarity with complex health care systems. Single parent households showed a significant tendency to receive regular care (59% versus 41% irregular care, p=0.001), but employed families were more likely to fall in the "irregular care" group (59% versus 45%, p=0.001). Other family factors were not significant predictors.

While family income did not differ significantly for the two groups, children in the "irregular care" group were more likely not to be covered by any type of insurance (40% versus 11%, p=0.005). Children covered by Medicaid were more likely to fall in the "regular care" group (57% versus 37% irregular care, p=0.001). These findings are particularly interesting in light of recent welfare reform efforts, which may move children from Medicaid coverage to unfunded status and, perhaps then, shift them from regular to irregular care.

Preliminary multivariate analyses, using logistic regression, indicate that immigrant status, language spoken in the home, and insurance coverage are most highly predictive of irregular sources of care for children. The possible implication of these findings in light of current state and national efforts to ensure universal coverage and care for children is discussed.

References

Klerman, L. V. (1992, Winter). Nonfinancial barriers to the receipt of medical care. *The Future of Children, 2(2)*, 171–185.

St. Peter, R. F., Newacheck, P. W., & Halfon, N. Access to care for poor children. *Journal of the American Medical Association, 267(20)*, 2760–64.

Navigating Medicaid Managed Care: The Connecticut Children's Health Project's Advocacy, Education, and Research

Ann Bonney

PRESENTERS: Katie Conrad, Laura Mullen, Sheila Nolte

The Connecticut Children's Health Project (CCHP) was created by the Connecticut legislature in 1995 to ensure that children receive the health care services to which they are entitled in Medicaid managed care. These health services—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)—are intended to provide primary health care and medically necessary specialty care for all eligible individuals from birth up to age 21. More than 200,000 children

and adults under the age of 21 are enrolled in Medicaid managed care in Connecticut and are affected by this health care delivery system.

The Connecticut Children's Health Project uses several important communication components to identify learning needs. One of these components is the Children's Health Infoline, a confidential telephone resource with bilingual care coordinators. Staff assist callers by answering questions, resolving problems, and helping callers to navigate the sometimes confusing system of Medicaid managed care.

Using multifaceted research tools, such as Children's Health Infoline data, telephone surveys, focus groups, and encounter data, CCHP has been able to monitor care and identify issues, trends, and gaps in services and information in the Medicaid managed care system. As a result, appropriate audience-specific materials, including videos, brochures, posters, and curricula have been developed, educational programs have been planned and implemented, state policies have been changed or clarified, and further studies have been proposed.

The sharing of research results also allows CCHP to identify policy issues affecting the delivery of health care services, including the behavioral health, dental, preventive, and treatment services to which consumers are entitled in Medicaid. The project has identified issues that have led to policy changes and clarifications and changes to the contracting process between Medicaid managed care plans and the state.

The CCHP also provides comprehensive education and training on children's health issues, EPSDT, and Medicaid-managed care that address the identified needs of consumers, medical providers, and advocates. The Children's Health Infoline responds to consumers' and providers' questions and concerns about Medicaid managed care. Care coordinators clarify health care needs and identify the causes of delays or denials in receiving services. Staff make multiple follow-up calls to assure that children and families receive the services to which they are entitled. The Children's Health Infoline staff members enable and empower consumers to file a grievance or appeal decisions and advocate for themselves. Staff assist and enable child advocates and providers to advocate for their clients.

The display included: (a) Brochures and other materials designed for specific audiences describing how to access health care services for children in Medicaid managed care; (b) Visual displays of EPSDT services to which children are entitled under Medicaid; and (c) Materials describing CCHP research results, educational activities, advocacy activities, and their impact on enhancing the delivery of health care services to children in Medicaid managed care.

Caring for the Children We Share: Politics and Promises in School-Based Health Services

Catherine Emihovich, Carolyn D. Herrington

PRESENTERS: Catherine Emihovich, Carolyn D. Herrington

Without question, children's lives are increasingly at risk in the United States today. Recent statistics provided by the National Center for Children in Poverty (1997) indicate that nearly half of children under the age of 6 live in poor or nearly poor families. These data are especially disturbing since researchers have documented that life in near poverty is detrimental to children's development while life in extreme poverty is deleterious to children's future life chances (Duncan, Brooks-Gunn, & Klebanov, 1994). As one way of coping with children's increased health and social services needs, 17 states have begun locating health care services directly in the place where most American children spend the bulk of their time: the public school (Making the Grade, 1997). Known by various names (full-service schools, school-based

health clinics), these schools offer a variety of services to improve the health and well-being of children, especially in school districts with a high incidence of medically underserved, high-risk children, low birthweight babies, high infant mortality, and rapidly rising rates of teen pregnancy and school violence (Dreyfoos, 1994). The health services provided to students often include a combination of initiatives such as health education, counseling, access to basic medical and social services, extracurricular activities to prevent juvenile crime, and self-esteem components.

A program in Florida that located health and social services directly in schools and its effects on selected educational and social outcomes for children and families was presented. The policy analyses for this paper were based on a 2-year, statewide evaluation of a supplemental school health program (Emihovich & Herrington, 1993). A total of 49 projects were funded that encompassed 192 schools. The evaluation drew primarily upon information collected from the following sources: (a) a survey of 2,572 students in project schools, (b) site visits to 12 counties with over 120 interviews conducted with focus groups, and (c) a review of all project-related documents. In addition, 3 of the original 12 sites were visited 3 years later to learn what had happened to the program during that time and to examine the effects of new factors not present in the original study (Emihovich & Herrington, 1997).

If these programs are to succeed, fundamental changes must occur in how schools are organized, the ways in which education professionals conceive their roles, and the means by which policymakers fund and hold programs accountable for delivering on their promises. We argue that if the conditions of children are to be restored to a level that is consistent with the ideals of a just and democratic society, a critical set of pre-conditions must be met: (a) a reconciliation of diverse discourses that honors compassion and consequences as well as rights and responsibilities, (b) a public policy framework that respects diversity and strengthens community, (c) a rethinking of the strengths and limitations of current institutions and the professionals who serve children, and (d) the establishment of a system of accountability designed to improve children's and families' well-being.

References

Duncan, G. J., Brooks-Gunn, J., & Klebanov, P. K. (1994). *Economic deprivation and early childhood development of children in welfare families.* In A. C. Houston, C. T. G. Coll, & V. C. McLoyd (Eds.), Special issue: Children in poverty. *Child Development, 65*(2), 296–318.

Dreyfoos, J. (1994). *Full service schools.* San Francisco: Jossey Bass.

Emihovich, C., & Herrington, C. D. (1993). *An evaluation of the effectiveness of Florida's Department of Health and Rehabilitative Services Supplemental School Health Services Projects.* Tallahassee, FL: Learning Systems Institute, Florida State University.

Emihovich, C., & Herrington, C. D. (1997). *Sex, kids, and politics: Health services in schools.* New York: Teachers College Press.

Making the Grade survey. (1997). Washington, DC.

National Center for Children in Poverty. (1997). *One in four.* New York: Columbia University School of Public Health.

Palmetto Children's Clinic—A Medical Home for Special Needs Children

Ronald C. Porter, Kathi M. Kelly

PRESENTERS: Ronald C. Porter, Kathi M. Kelly

Many children in the United States do not receive adequate primary care services. Research has shown that children least likely to receive care according to guidelines developed by the American Academy of Pediatrics were from low-income families, had poorly educated parents (eighth grade education), had mothers who were African American, and were from families of six or more persons. Health care costs skyrocket when poor families cannot access routine doctor's visits and resort to costly emergency room use for nonemergency or preventive care.

Children with special health care needs face even greater barriers to adequate primary care than children without disabilities. These children frequently see many medical subspecialists and a variety of other health professionals. Without a primary physician to provide a medical home, these children are subjected to fragmentation of care, poor communication among providers, and lack of continuity and coordination of care.

The Palmetto Children's Clinic (PCC) was established in 1994 to address primary health care needs of children with severe disabilities living in Richland County, South Carolina. The clinic is a joint venture between a public, not-for-profit hospital, a University Medical School, and the state Department of Health and Environmental Control's Children's Rehabilitative Services Branch (CRS) which administers the Title V program. The clinic provides a medical home for special needs children enrolled in the CRS program and is staffed by a full-time pediatric nurse practitioner and a clinic manager. Medical supervision is provided by the USC Medical School, Department of Pediatrics. Palmetto Richland Hospital provides support and clinic space.

After the 1st year's experience, a formal satisfaction/quality of care survey instrument was developed and data were collected. Among the important findings were that 68% of parents in the PCC were "much more" or "a little more" satisfied with the care their child received than with the previous source of care. Data on usage of the emergency room and inpatient hospitalization were collected and compared to the patients' pre-enrollment data and to a control group of special needs children without medical homes. After 1 year, no significant differences were found in the use of the emergency room pre and postintervention either within or between groups. However, comparison of hospital admissions between PCC patients and the control group indicated a statistically significant difference. Likewise, comparison of kept appointment rates and EPSDT show rates between PCC and the general pediatric clinic demonstrated statistical significance. The immunization completion rate (birth to 2 years) was significantly higher than the state average.

Evaluation of the 2nd year's experience continued to reveal the statistically significant difference in hospitalization rate. Emergency room use, although not significantly reduced, was deemed appropriate by medical standards more than 75% of the time. Palmetto Children's Clinic parent satisfaction was compared to satisfaction with the general pediatric clinic and again revealed significantly greater satisfaction in all areas questioned. Kept appointment rates, EPSDT show rates, and immunization completion rates continued to outpace comparison groups.

Using Hospitalization Data to Describe Community-Based Program Effects

Sharon Ogden Burke, Jacquelyn Gerlach

PRESENTER: Sharon Ogden Burke

Better Beginnings, Better Futures Programs have been developed by selected Ontario, Canada, communities at socioeconomic risk. The goals of these community-based, primary prevention programs include promotion of healthy child development and prevention of emotional, social, physical, and cognitive problems. Health outcomes are expected from program components, such as home visiting, nutrition programs, and prenatal education. Evaluation of program effects includes child, family, and community level indicators of social, educational, and health outcomes. The primary method for evaluating health outcomes is a 25-year longitudinal study of the children in these communities. As programs are open to all families within study communities, an analysis was done of geographically based secondary indicators, such as hospitalization data, to provide insight into baseline status and program effects.

The poster presented: (a) a method for evaluating health and economic outcomes of community-based primary prevention programs and (b) early indications of Better Beginnings, Better Futures effects on hospitalizations of young children. Data were obtained from the Canadian Institute for Health Information (CIHI) database, which has discharge summary data for every Canadian hospitalization. Seven program communities were studied. Study communities, their surrounding metropolitan areas, and the rest of Ontario were geographically defined by voting areas and associated postal codes. The provincial comparison group controls for system-wide changes, such as falling numbers of admissions and shorter stays. Surrounding area comparisons control for local variations, such as hospital or physician practice patterns.

An SPSS program was developed for analysis of CIHI data over the 25-year life of the project. Pediatric hospitalization data have been analysed for 2 preprogram baseline years and an early program year. (Analysis is in progress on more preprogram and program years and on newborn and maternity hospitalization data.) Rates for hospitalizations and complications were determined for high and moderate volume Case Mix Groupings and International Classification of Diseases-9 most responsible diagnoses at discharge. Descriptive statistics were generated for length of stay, cost, total bed days, admission, and discharge status.

For the most part, across baseline and early years of programs, length of stay and cost were similar for program communities and their surrounding areas. However, infectious diseases, asthma, low birth weight, and a number of other conditions showed substantially higher hospitalization rates (30-100%) in Better Beginnings communities before programs began. In some instances, rates have fallen after program implementation, such as hospital days for children from birth to age 4 with an injury and poisonous ingestion. Generally, hospitalization rates, rather than longer hospital stays or high costs per stay, explained relatively higher bed days and costs in Better Beginnings program communities.

Substantially higher preprogram rates of hospitalization for certain conditions, such as infection, trauma, and asthma, support the need and potential for primary prevention through research-based, community-run programs, such as those offered by the Better Beginnings, Better Futures Program. Early results also show promise for the utility of hospitalization data in tracking effects from such programs.

Professional Development of Head Start Teachers in Latino Communities: Effects of a Violence Prevention Program

Nancy Amodei, Elizabeth Taylor, Tom Hoffman, Anna Madrigal, Joan Biever, Fred Cardenas

PRESENTERS: Nancy Amodei, Elizabeth Taylor

Youth in the U.S. are victims of, perpetrators of, and exposed to violence. A tool of violence prevention is early childhood education. Head Start teachers in rural South Texas, which has a large Hispanic population, were recruited to receive a newly developed violence prevention training intervention. The effectiveness of that training in influencing knowledge and attitudes was tested.

Teachers were recruited from three rural South Texas programs: the Texas Migrant Council (TMC), the San Felipe Del Rio Consolidated Independent School District (SFDR), and the Education Service Center, Region 20 (ESC). They were nonrandomly assigned to a control group (n =23) and two intervention groups (i.e., long intervention [n = 34] and brief intervention [n = 27]).

Two forms of training were given: (a) a long, 6-hour session conducted over 1 day (long intervention) and (b) two brief 3-hour (half-day) sessions held 2 months apart (brief intervention). Teachers from TMC were recruited to be in the control group and the brief intervention. Teachers from SFDR and ESC participated in the long intervention.

The content covered in both formats of the curriculum was identical. The major topics covered were as follows: (a) definitions and meanings of violence, (b) epidemiology and statistics, (c) effect of violence over the lifespan, (d) creating a nonviolent atmosphere in early childhood settings, (e) emotional responses of young children to violence, (f) teaching young children to resolve conflict peacefully, (g) handling teacher-parent conflicts, (h) using positive discipline with children, (i) personal anger management, and (j) commitment to change.

Violence prevention knowledge and attitude scales were constructed for the present study from the pretest responses of 102 teachers and were tested for both validity and reliability. The following scales resulted: General Knowledge About Violence, Specific Knowledge About Violence, Violence Prevention Competency, Violence Prevention Attributes, Role Efficacy, and Remediation Competency. Repeated measures analyses of variance and multiple regression were used to test the major hypotheses.

Posttest scores in Remediation Competency and Violence Prevention Attributes improved significantly over pretest scores. This increase in Remediation Competency scores was of a greater magnitude for those who participated in the brief modality of the curriculum. General knowledge about violence posttest scores was increased by having participated in the long modality of the curriculum and by having had previous experience with violence. Higher final scores on the general knowledge indicator resulted in higher final scores on the Remediation Competency indicator.

The program appears to be effective. It enhanced both knowledge and attitudes towards violence prevention. The training modality had some impact on the outcomes. The longer modality could be seen as more effective in so far as it increases general knowledge, which, in turn, increases remediation competency. While educational level and teaching experience do not have an impact on this program's effectiveness, previous experience with violence does.
It is hoped that this study will encourage further development and implementation of violence prevention curricula for teachers involved in early childhood training such as Head Start.

Caregiver Contact and Cultural Sensitivity as Predictors of Successful Future Care and Custody Planning With HIV-Seropositive Families

Beatrice J. Krauss, Dina Franchi, Susan Letteney, Fran Silverman

PRESENTER: Beatrice J. Krauss

Families in Transition (FIT) is a New York City hospital/community collaboration designed to identify HIV-positive parents with minor children and to facilitate authorship of legally binding plans for the continuous care of children during parental hospitalization, debilitation, or after parental death. With collaboration from the Legal Aid Society, FIT social workers provide a full range of professional services (e.g., support groups). Employed community members furnish outreach and ancillary services (e.g., babysitting). Services are free through New York State Department of Health's AIDS Institute support.

The typical FIT client is a woman (96.4%), 35 years of age (M=35.2), with some high school education, an average income of $13,900, and 1.75 children (64% of whom are under the age of 15), and without other adults in the home to support the parenting role (69.6%). Clients are largely Latino (47.7%) or African American (34.1%). One fifth are referred through street outreach, a small percentage (7%) by medical personnel, and the remainder (72%) by hospital, community, and school social service providers.

Sixty client charts were sequentially selected for analysis. Language preference, referral source, and reasons for referral were noted. Intake interviews documented age, ethnicity, religion, education, household composition, role in household, income, employment, medical insurance, disabilities, financial assistance needs, other contact with hospital services, and persons present at intake, and verified clients' presenting problems.

The dependent variable was program success (present=1, absent=0), defined by authorship of legally binding standby or permanent guardianship or successful family adjustment with no further need for services (i.e., in the case of a surviving spouse). Independent or predictor variables achieving bivariate correlation with program success at p=<.15 were entered into a logistic regression equation, with unchangeable characteristics of clients (e.g., ethnicity) entered first and variables amenable to intervention second.

Medical referral (r[54]=.34, p=.009), fear of abandonment on disclosure of HIV status (r[54]=- .28, p=.037), Latino ethnicity (r[54]=.510, p<.001), and contact with the potential caregiver (r[54]=.70, p<.001) were significantly related to program success (p<.05). Referral by an outreach worker (r[54]=-.24, p=.073) and number of sons under 15 (r[54]=.21, p=.12) also passed screening criteria. Only contact with caregiver and Latino ethnicity remained significant in multivariate analysis (p=.0001).

The odds of successful program completion were 14 times higher (p=.0009) for families in which a FIT social worker had consultative contact with the caregiver and were 5 times greater (p=.02) for Latino clients.

Generally, the FIT social worker meets jointly with the parent and potential caregiver to discuss two issues: (a) the specifics of the new caregiver's parenting role, and (b) joint agreement that the parent's wishes for childrearing will be honored. In our preliminary data, such contact overrides the clients' initial fears of abandonment and should be considered in permanency planning program design for HIV-affected families.

Cultural sensitivity also appears important in enacting future care and custody plans. More than half of White and African American clients were lost to follow-up due to the inability to find and re-engage these clients. No Latino parents were lost to follow-up, possibly due to the efforts of our largely Latino outreach staff and hospital experience with a Latino population.

Early Undernutrition and Play

Helen Walka, Ernesto Pollitt

PRESENTER: Helen Walka

Children in the study were 24–30 months of age within the nutritionally at-risk population of the tea plantations of West Java, Indonesia. Study participants receiving a high energy plus micronutrient intervention demonstrated shorter inhibition time and increased duration of play and chose to play with more toys during longitudinal assessments of spontaneous play.

These findings have implications for interventions aimed at low-income families with infants and toddlers in U.S. populations. Epidemiological reports have found that subgroups of young children in the U.S. are at risk nutritionally, especially for iron deficiency anemia. This play study suggests that lowered interest in play and interaction with objects may represent an additional risk factor for these infants and toddlers. Multifaceted interventions including nutritional intervention are essential for infants and toddlers from low-income families and low-income, pregnant mothers.

Asthma Education in Head Start

Lenore Coover, Oscar Solano-Forero, Clarissa Banos-Rivas, Sharon Telleen, Victoria Persky

PRESENTER: Lenore Coover

This poster session described and depicted a process of collaboration among researchers, health educators, a graphic artist, Head Start staff, and Head Start families to address issues related to the high incidence of asthma in underserved communities in Chicago and to respond to identified issues related to asthma in Head Start programs. Asthma mortality rates in Chicago are among the highest in the nation. A group of researchers from the University of Illinois in Chicago, School of Public Health, surveyed Head Start families in four diverse community areas of Chicago. Results showed that 14% of Head Start children had been diagnosed with asthma and 19% had wheezed within the last year. Related risk factors included low birth weight and reports of smoking, animals, and dampness or mold in the home.

Focus groups were held with health care providers servicing the Head Start programs, health coordinators, teachers, and parents within the program to explore factors that might be affecting the children's diagnosis, management, and overall function. The need for more integrated programs aimed at identification and amelioration of factors in individual children's homes and Head Start sites that could be contributing to the disease was identified. Across all focus groups, participants expressed a need for education materials suitable to the community. Head Start staff felt that training programs specifically focused on asthma prevention and treatment would be helpful.

As a result of the recommendations, asthma education materials that were culturally sensitive to the targeted communities as well as bilingual (Spanish and English) were developed. Training sessions were made available to the staff once a month during the school year and more than 400 staff participated. Head Start parents were trained as community educators to provide asthma education and environmental assessments of homes and Head Start sites for asthma triggers. Some of these parents were subsequently hired to continue and expand this service in their communities. Feedback from parents of children with asthma and the Head Start staff was positive.

A research grant funded by the Maternal and Child Health Bureau, U.S. Public Health Service (S. Telleen, Principal Investigator), identified the areas of greatest need in Chicago as health

services for Mexican and Puerto Rican children, including the treatment of asthma. Based on these findings, staff from the University of Illinois in Chicago, School of Public Health, in collaboration with Fulbright Scholars attending the university and community workers, developed the educational materials. The materials were based on *Guidelines for Diagnosis and Management of Asthma* (National Asthma Education and Prevention Program, 1997).

References

National Asthma Education and Prevention Program, National Heart, Lung, and Blood Institute, National Institutes of Health. (1997). *Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma*. Bethesda, MD: Author.

Development of a Model Child Health Clinic Home Visitation Program

Janet Graves, Esther Hellman, Dianne Travers-Gustafson, Beth Furlong

PRESENTER: Beth Furlong

The development of a model child health clinic home visitation program was described. Based on Title V grant money, these researchers worked in collaboration with the Child Health Clinics Advisory Committee (CHCAC) and with the Colorado Foundation for Families and Children. The CHCAC wanted to implement a home visitation program to serve the vulnerable families for whom they provided health care. The six clinics in Omaha who belong to this CHCAC are the main health providers for the population of vulnerable children and women. In receiving the contract from this CHCAC, the goal of the authors was to research and analyze the literature to determine the best practice model of home visitation. The literature review incorporated home visitation models in several disciplines, such as nursing, social work, early childhood education, and so forth. This work resulted in the recommendation of the Olds model, which is a public health-nursing model. In researching the literature, criteria of randomized trials and documented outcomes were utilized to assess the adequacy of the variety of home visitation approaches utilized in many disciplines. There were many programs in existence; however, it was only the Olds model that met the above two criteria. In addition, data were gathered from a variety of clinics, public health/home health agencies, and social service agencies in the Omaha, NE, area to assess strengths, limitations, and needs relative to home visitation. During the year while the data were gathered, the authors participated in multiple community, state, private, and public sector meetings concerning policy making. For example, the Nebraska Department of Health and Human Services was going through unprecedented reorganization which will have an impact on future funding and delivery of health and human services. Further, a city-wide private sector initiative of the United Way, the Roundtable, was also going through challenging organizational changes. The authors were attentive to these and other political and policy changes that would have a bearing on home visitation services.

The recommended model was accepted for implementation by the CHCAC and is now being implemented in Omaha by three agencies: Creighton University School of Nursing, St. Joseph Villa Home Care and Hospice, and the Visiting Nurse Association. Thus, Omaha will be one more testing site for the Olds model. The model includes protocols for the public health nurses who are implementing the home visits, that is, home visits are begun during pregnancy and children are followed for 2 years. The public health nurses are educated in specific protocols and expectations for each home visit and the documentation of such interventions. There are criteria for the selection of vulnerable families as well as criteria for the frequency of home visits. The positive health outcomes of utilization of the Olds model include a wide range of benefits.

Monitoring EPSDT Under Medicaid Managed Care

Mary Alice Lee, Judith Solomon

PRESENTER: Mary Alice Lee

The Children's Health Council (established by the Connecticut General Assembly, developed and implemented by the Hartford Foundation for Public Giving, and operated under a contractual agreement with the State of Connecticut Department of Social Services) has developed and implemented a system for tracking children's health services and monitoring health plan performance in Connecticut's Medicaid managed care program. Participation in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is assessed over time and across health plans, using enrollment and encounter data to estimate the EPSDT On-Time Visit Rate. The Council reports results to the State Medicaid agency.

The EPSDT program entitles children covered under Medicaid to a broad package of health care benefits, administered with an emphasis on prevention and aggressive outreach to bring children in for care. In consultation with professional groups, such as the American Academy of Pediatrics (AAP), states have developed schedules for comprehensive screening examinations that are performed at regular intervals throughout the child's life. These visits should include well-child medical, dental, vision, and hearing assessments; immunizations; laboratory tests; health education; and anticipatory guidance. Federal goals established for 1995 and beyond require states to assure that at least 80% of EPSDT recipients receive timely screening examinations.

At the direction of the Children's Health Council, the Connecticut Children's Health Project (operated by MAXIMUS, Inc., of McLean, VA, under a subcontract with the Children's Health Council) tracks EPSDT screening examinations and monitors EPSDT participation at the program and health plan level. Using Medicaid managed care enrollment files, children who are due for screens by age are identified. Then the health plans in which they are enrolled are notified 2 months in advance. Health plans are then responsible for notifying families and providers. Using encounter data submitted by health plans, children who are overdue 90 days or more for well-child screening exams are identified and the health plans are notified. After allowing providers and health plans 180 days for submission of encounter records, the Project's encounter database is searched for records indicating that timely comprehensive screening visits took place. The window of time in which a visit is considered "on time" varies by the age of the child and the frequency of recommended screens. Encounter records must be coded according to the Department of Social Service's uniform coding and reporting requirements. The EPSDT On-Time Visit Rate is calculated quarterly by age, by health plan, and by county. Screening rates for children in the custody of the Department of Children and Families (DCF) are also reported.

Results of performance monitoring indicate that EPSDT participation is low. Less than half of children due for screens were screened on time. EPSDT participation varied by age and by health plan and was lower for children in DCF custody. The accuracy of enrollment data and the completeness and timeliness of encounter data submissions have affected the ability to track services and monitor performance.

EPSDT tracking and performance monitoring are essential to evaluating the impact of Medicaid managed care and improving EPSDT participation. Quantitative measures of participation, such as the EPSDT On-Time Visit Rate, should be used to supplement other information about access and utilization obtained from community-based providers, focus groups, satisfaction surveys, and calls to a hotline or ombudsman program. (The Connecticut Children's Health Project operates a Children's Health Infoline under a contract with the United Way of Connecticut Infoline.) The ability to monitor children's health services under Medicaid managed care is dependent entirely upon contracts with health plans that include goals for EPSDT participation and requirements for timely and complete submission of encounter data.

External quality assurance reviews of a Medicaid managed care program should include EPSDT medical record audits and encounter data validation. The results of performance monitoring can stimulate program improvements, including collaboration between health plans and community-based programs, such as Head Start, aimed at improving EPSDT participation.

Health Education for Young Children

Connie Jo Smith

PRESENTER: Connie Jo Smith

Learning to live a healthy lifestyle begins during the early years of life. For many children, the need for health and safety education becomes a significant reality much too early. Each day, approximately 37 children die from injuries and 685 children are arrested for alcohol or drug offenses. Most injuries, and many of the unhealthy lifestyle choices involving children, can be prevented when safe and healthy habits are integrated into the classroom curriculum in a nonthreatening, natural way. Infusing the curriculum with health-related information addresses the total day-to-day needs of each child and helps the children practice habits that may well save their lives.

Research shows that young children can and do gain health knowledge, develop skills, and acquire healthy promoting behaviors when appropriate health education is integrated into their daily curriculum. Effective health education cannot be accomplished by telling children about health and illness nor can it be addressed adequately with an occasional unit, routines, or incidental learning. It requires that children understand the concepts and develop the necessary intellectual tools.

Effective health education for young children includes appropriate topics and content, fun learning activities which extend learning and reinforce concepts, daily routines, a supportive environment, an assessment to determine where children are on a continuum of health knowledge and skill, and parent involvement. Effectively integrating health education also requires a partnership between early childhood education and health education professions.

Several resources are available which reflect this partnership. Growing, Growing, Strong (Smith, Hendricks, & Bennett, 1997) is a comprehensive health education curriculum which allows teachers to customize their approach to meet their classroom goals and the children's goals. The Learn Not to Burn preschool program is a topic-specific curriculum. Through use of both comprehensive and topic-specific health education materials, early childhood educators can foster a strong foundation for healthy lifestyles.

References

Smith, C. J., Hendricks, C. M., & Bennett, B. (1997). *Growing, growing, strong.* St. Paul, MN: Redleaf Press.

National Fire Protection Association. (1991). *Learn not to burn preschool program.* Quincy, MA.

Promoting Child Health and Enabling Parents Through Health Education

Charlotte M. Hendricks

PRESENTER: Charlotte M. Hendricks

Health education can increase parents' awareness of health and provide information to enable parents to promote family health. Issues facing families with young children are numerous, ranging from safety, injury prevention, and disease prevention, to discipline and social/emotional development. Child safety and injury prevention information is essential as each year, more children die from unintentional injuries than from all childhood diseases combined. Disease prevention education is also crucial; nationally, less than 60% of children are up-to-date for the recommended primary immunization series. Utilizing health services is also important. When an injury or disease occurs, parents can help their child by recognizing the need for medical treatment and seeking treatment through appropriate community resources.

It can be challenging to provide health education programs for parents. Limited time and resources, available child care, and transportation are potential barriers to traditional training schedules. Utilizing a wide variety of health education approaches not only alleviates some barriers, but also appeals to parents by incorporating many learning approaches.

The JCCEO Head Start program in Birmingham, Alabama, addresses parent health and safety education in several ways. First, the Hip on Health (Hendricks, 1997) series has been used successfully for 5 years. Fieldtested in 1995 through a NHSA Partnership Challenge Grant, these materials consist of reproducible miniposters and parent take-home information sheets on a variety of health-related topics.

Reproducible parent information and activity sheets are included in Growing, Growing, Strong (Smith, Hendricks & Bennett, 1997), a children's comprehensive health education curriculum. Through these sheets, parents receive information regarding children's health and development, reinforce their child's learning through at-home activities, and become more involved in classroom activities through requested sharing of experience, items, or materials.

Healthy Child Care (Breighner, 1997), a magazine for child care programs, is devoted entirely to child health and safety. Each issue includes not only staff information on health and safety issues, but also information for and ways to communicate health information to parents. Other materials distributed include Partners in Parenting, published bi-monthly by The Children's Health System, monthly menus and nutrition information, a community resource directory, the Childhood Injury Prevention Handbook, and information on fire and burn prevention, bike safety, and child abuse and neglect.

Parents can also check out books, tapes, and videos through each classroom lending library, and bulletin boards are an effective way to reach many parents. In a more traditional training style, the parent involvement coordinator conducts parent workshops on a variety of topics such as child abuse and neglect, child and adult mental health issues, and safety and injury prevention. Through the Male Involvement Project, fathers are involved in workshops such as Developing Male Parenting Skills, which includes a puppet show to illustrate problem solving and conflict resolution.

By utilizing these best practices, Head Start programs can incorporate successful parent health education and promote the health and well-being of young children and their families.

References

Hendricks, C. M. (1997). *Hip on health*. Kent, OH: American School Health Association.

Smith, C. J., Hendricks C. M., & Bennett, B. (1997). *Growing, growing, strong*. St. Paul, MN: Redleaf Press.

Breighner, K. (1997). *Healthy child care*. Harbor Springs, MI: Healthy Child Publications.

When Communities Take Charge: A Bottom-Up Approach to Improving the Well-Being of Young Children

Stacie S. Cherner, Kathleen M. Hebbeler

PRESENTER: Kathleen M. Hebbeler

Historically, many policy efforts to improve the lives of young children have been both categorical and top down. They have been categorical in that program designers identify a target population such as children at risk for abuse and neglect or a problem area such as school failure. These efforts are top down insofar as critical parameters of the program are identified at the national or state level and then communicated to those who implement the program in local communities.

The Community Partnerships for Healthy Children (CPHC) initiative contrasts sharply with more traditional policy efforts. The 26 northern California communities participating in CPHC have been engaged in a multiyear process of identifying the most pressing issues for children and families in their communities and developing their own approaches to address these issues. The CPHC, funded by the Sierra Health Foundation, is based on the core belief that families and communities are responsible for the health needs of children.

Findings from the evaluation indicate that during the first phase of the initiative (1994-1996), communities formed or restructured a collaborative composed of agency and citizen members. Members shared and continue to share a strong commitment to the mission of the collaborative. The collaborative conducted a community assessment to identify the needs of children and families and the resources available to address these needs. Based on the assessment, one or more target issues was identified. Examples include child abuse, family violence, parenting, child care, and lack of recreational opportunities.

Issue identification was followed by a planning process through which the collaboratives produced a strategic action plan for the community. The evaluation revealed that the planning phase (1996-1997) was difficult because the technical complexity of the process was a barrier to citizen participation. Many citizen members also were more interested in working in the community than in planning. Communities selected are now implementing a wide variety of strategies such as new or expanded after-school recreation programs, parenting classes, community events, and public awareness campaigns. Strategies are relatively low cost and most draw heavily from resources available within the community. In addition to outside grant funds, collaboratives were able to secure donations of space, equipment, land, materials, food, and expertise from within the community.

Collaboratives identified child outcomes and corresponding indicators that they are seeking to impact through their strategies. Collaboratives are collecting data on indicators at regular intervals over the next several years. Data on outcomes will provide the basis for determining whether this community-based approach to problem identification and solution implementation can improve the well-being of children and families. Thus far, the evidence indicates that when provided with resources and technical assistance, communities can identify the policy issues facing their families and design and implement strategies to address these issues. Although this "bottom-up" approach to improving the health of children has been challenging, it also holds promise because it continues to be driven by the commitment of those who live and work in the communities of the children whose lives they hope to change.

Lead Poisoning in Young Children: Enhancing Prevention Effects Among Early Childhood Educators

Lora Tuesday Heathfield, David D. FitzGerald, Andrea Weiss, Jerilynn Radcliffe

PRESENTER: Lora Tuesday Heathfield

In the United States, an estimated 1.7 million preschool-age children have levels of lead poisoning that place them at risk for adverse neurologic, behavioral, and growth effects. The magnitude of lead poisoning among young children warrants greater dissemination of lead poisoning information and increased prevention efforts. Information on: (a) environmental lead hazards, (b) current research findings on the developmental effects of lead exposure, (c) symptomology that may be indicative of childhood lead exposure, and (d) specific strategies for enhancing the prevention of lead poisoning is provided.

(Abstract from original proposal; paper summary not available for publication.)

Children's Health Resources

Marilyn S. Massey, Charlotte M. Hendricks

PRESENTER: Charlotte M. Hendricks

Quality children's health resources are extremely important in promoting the health and well-being of children. Challenges in promoting children's health include accessing accurate information and locating appropriate health education materials. Parents and teachers are assisted in judging the quality of health-education resources and identifying sources of appropriate materials.

(Abstract from original proposal; paper summary not available for publication.)

Loud and Clear—Ear Infections: Implications for Language, Learning, and Behavior and What is Sensory Integration Dysfunction

Beth Davis-Wellington

PRESENTER: Beth Davis-Wellington

A critical look at ear infections, both in terms of medical management and implications for future learning and behavior issues for the child, was presented. A review of education literature and occupational therapy practice and research in the area of Sensory Integration Dysfunction and Sensory Integration Therapy was included.

(Abstract from original proposal; paper summary not available for publication.)

Infants and Toddlers

Outreach to Primary Care Providers: An Effective Way of Improving Developmental Screening and Referral of At-Risk Birth to 3-Year-Olds?

Yalonda Corbin, Caroline Donahue, Harris Huberman, Katherine Lobach, Nora Townley

PRESENTER: Jennifer Miley

Early Intervention (EI) programs funded under PL 99-457 Part C seek to prevent or mitigate the human, societal and financial costs of undetected developmental delays in the birth to 3-year age period. "Child Find," or early detection and referral of children with potential delays, represents a crucial component of the EI system (Meisels & Provence, 1992). A central component of the Child Find approach is to assure the continued engagement of children in primary health care. While social workers, day care, and educational personnel as well as parents can and should be attuned to child development issues and make referrals to EI, the main role of providing developmental screening falls to the pediatric primary care provider (PCP).

Pediatric primary care is often the only place where at-risk infants and toddlers come to the attention of professionals (AAP, 1994). Increasing attention has been placed on assuring a medical home for all children. However, two types of obstacles exist. The first is that many at-risk infants either never find their way into an appropriate medical home or become disengaged from care and lost to follow-up. The second is provider training and capacity to do screening. While most pediatric providers subscribe to the value of formal developmental screening promulgated by the American Academy of Pediatrics and others, in practice few go beyond informal surveillance unless considerable effort is brought to bear to encourage it (Smith, 1978; Belcher, 1996).

Several Part C Child Find programs, including New York City's Infant Child Health Assessment Program (ICHAP), are based on a model in which public health resources are used not to duplicate but rather to support and complement existing primary health care networks. Outreach is made to primary care providers (PCPs) who are given training in child development and the use of specific screening tools. Additionally, tracking systems are put in place to remind PCPs when they should screen individual at-risk children in their care and for the PCP to efficiently report back the results to the ICHAP. In this model, public health workers play a safety net role and only become involved with families either initially when an at-risk infant is not properly referred to a primary care home by the birth hospital or subsequently when PCPs report that the child has fallen out of care.

Between 1993 and 1997, ICHAP (administered by the Medical and Health Research Association of New York City, Inc., under contract with the NYSDOH) held approximately 800 meetings to orient providers to the Early Intervention system in New York City. In addition, ICHAP provided formal developmental training sessions to 503 providers representing 165 different health care sites. These sites provided care to approximately half of all at-risk birth to 3-year-old children who had been referred to ICHAP. During these meetings and training sessions, providers were given information on child development, how to interface with the Early Intervention system, and formal training in the Denver II Developmental Screening Test. Follow-up onsite visits with individual providers were conducted to assure their proficiency in

the screening and to promote the site's implementation of the tracking system. The basic message of the training was the importance of maintaining a high level of awareness of developmental issues, of the need to conduct formal screening on all at-risk children, and of the NYSDOH mandate to promptly offer EI referrals in all cases of suspected delay.

Sites prioritized for outreach during this period were chosen on the basis of serving large volumes of at-risk children and included both hospital out-patient departments (48%) and community-based and other sites (52%). This study proposes to examine whether such public health efforts in fact improve PCPs developmental awareness and result in higher rates of detection and referral of children with suspected delay to EI. A comparison of the rate of referrals to EI before and after ICHAP outreach provides a method to evaluate the impact of the ICHAP outreach efforts. The sites will also be examined as to both provider characteristics (for example, municipal vs. voluntary, hospital-based vs. community-based) and population characteristics. Aggregate data obtained from KIDS, the NYSDOH Early Intervention Program data system, on the number of EI referrals made from different primary care sites, adjusted for the volume of birth to 3-year-old children seen by each site, will be used to calculate the rates of EI referral for the total birth to 3-year-old population before and after ICHAP outreach will be calculated and compared.

The degree to which ICHAP outreach efforts correlate with increased rates of EI referral will be presented in discussing the effectiveness of this outreach strategy toward improving the developmental awareness among the primary care provider community. Other approaches that Part C programs can use to collaborate with the health care system will be discussed in more detail.

References

American Academy of Pediatraics, Committee on Children with Disabilities. (1994). Screening infants and young children for developmental disabilities. *Pediatrics, 89*(2), 340–342.

Belcher, H. M. (1996) Developmental Screening. In A. J. Capute & P. J. Accardo, (Eds.), *Developmental Disabilities in infancy and childhood: Vol I. Neurodevelopmental diagnosis and Treatment,* (pp. 323–340). Baltimore: Brookes.

Meisels, S., & Provence, S. (1992). Screening and assessment: guidelines for identifying young disabled and developmentally vulnerable children and their families. *Zero to Three.* Arlington, VA .

Smith, R. D. (1978). The use of developmental screening tests by primary care physicians. *Journal of Pediatrics, 93*(3), 524–527.

The Effects of Secure Attachments on Preschool Children's Conflict Management Skills

John E. Kesner

PRESENTER: John E. Kesner

Recent research indicates that the majority of conflicts children face are either unresolved or resolved in destructive ways. Certain factors such as the child's gender, socio-economic status (SES), and being from a single parent home are thought to put the child at risk for higher levels of aggression. Bowlby's attachment theory (1969, 1973, 1980) provides a theoretical framework for understanding how children's early attachment relationships influence their social functioning (i.e., conflict management).

The purpose of this study was to examine the relationships between children's conflict management skills and their attachment relationship to parents and teachers. It was hypothesized that security of attachment to parents and teachers will both uniquely predict conflict

management in a model that includes salient demographic factors, including children's SES, gender, and single parent family status.

The sample for this study consisted of 66 preschool-aged children. Forty-four percent of the sample was male and 56% was female, with an average age of 57 months. The sample was predominantly African American (71%), but also included Hispanic (17%), Caucasian (9%), and other racial groups (3%), with a wide range of SES groups represented in a fairly normal distribution. Forty-five percent of the sample came from single parent homes.

At the beginning of the year children participated in two story completion tasks. The first was the Attachment Story Completion Task (ASCT; Bretherton, Ridgeway, & Cassidy, 1990) which assessed the security of the relationship with parents. Approximately 1 week later, a Conflict Story Completion Task (CSCT) was administered to the child. The CSCT dealt with school-based conflicts that the children may encounter. Several months later, a second round of story completion tasks was administered to the children. A Teacher Attachment Story Completion Task (TASCT) was utilized to assess the relationship with the teacher instead of the parent. The CSCT was again administered to the children. Demographic information was also collected from parents.

A stepwise multiple regression was carried out to determine the ability of demographics and attachment to parent and teacher variables in predicting conflict management. Results indicated that the only predictor of conflict management was security of attachment to parent. The original hypothesis was not supported by these results. Children's attachment relationship to their parents was a significant predictor of conflict management, but not their relationship to their teacher. Children that were securely attached to their parents had more constructive conflict management strategies than those with less secure relationships.

These findings are significant for two reasons. First, it further supports the importance of the initial adult-child attachment relationship. Attachment theory contends that the early attachment relationships lay the groundwork for all future relationships. Some of these children had what is usually considered risk factors for development (i.e., single parent status, low SES) yet none of these factors were significant in predicting conflict management. These results are also significant in that the conflict stories involved school-based conflicts, again indicating the influence of the parent(s)-child attachment relationship into other social arenas.

References

Bowlby, J. (1969). *Attachment and loss: Vol.1 attachment.* New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss : Vol. 2 separation, anxiety, and anger.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol. 3 loss.* New York: Basic Books.

Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). Assessing internal working models of the attachment relationship. In M. Greenberg, D. Cicchetti, & E. Cummings (Eds.), *Attachment in the preschool years.* Chicago, IL: University of Chicago Press.

Assessment of Parental Attitudes and Perceptions of Infant Competence: Implications for Social-Communicative Development

Paula L. Horner

PRESENTER: Paula L. Horner

Parental perceptions and attitudes about early development have tremendous impact on early interactive success. Researchers note that adult perceptions of infant competence enable adults

to conceptualize, and react to, the infant as a communicative partner, and these perceptions seed the development of adult-infant interaction. Parental attitudes toward and perception of infant behavior can greatly affect the reciprocal process through which the dyad becomes a true social partnership.

The early parent-child relationship is a dynamic process that is continually being modified by the parent's perception of the child's behaviors. It has been proposed that the effective assessment of young children needs to be based upon the assumption that parent-infant relationships are cyclical in nature, and that the ways that parents relate to their infants are modified by their perceptions of the baby's behaviors, which in turn modify infant behaviors toward the parent. By having parents predict certain infant characteristics or behaviors, parental perceptions of infant competence would be sufficiently influenced to change the ways in which parents interacted with their babies. This, in turn, would foster different levels of later child development. This body of empirical evidence, which has been strengthened over the years, underscores the need to examine how practitioners can successfully assess the influence of parental attitudes on the development of social and communicative abilities of infants.

Results were reported from the qualitative research study that was designed to reflect how adult perceptions and attitudes toward language development enabled parents to conceptualize and react to at-risk infants as communicative partners. Data were presented through a series of descriptive profiles concerning attitudinal and perceptual trends exhibited by mothers of developmentally at-risk infants between the ages of 3 to 6 months and 9 to 12 months. The two assessment methodologies used in the study are discussed. They are (a) an attitudinal rating scale that explored parental knowledge of and expectations about language development as well as perceptions of the infant's current level of communicative competence; and (b) a standard closed-ended interview that allowed parents to express their ideas about language development in their own words. Also highlighted was the relationship between parental knowledge, perceptions, and interactive performance with regards to early social and communicative development.

Results of the study indicated consistent trends across parental descriptions of infant social communicative behaviors, but substantial inconsistency in descriptions of parental roles in development and predictions of future developmental changes for at-risk infants. The nature of these adult perceptions and attitudes was addressed. Information for the designing of intervention programs that can be tailored to the specific areas of need for infant-parent dyads was provided.

References

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth.* Reading, MA: Addison-Wesley.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International University Press.

Klass, C. S. (1996). *Home visiting: Promoting healthy parent and child development.* Baltimore, MD: Paul H. Brookes.

Meisels, S. J. (1992). Early intervention: A matter of context. *Zero to Three, Vol. XII,* No. 3, 1–6.

Trad, P. V. (1990). *Infant previewing: Predicting and sharing interpersonal outcome.* New York: Springer-Verlag.

Trad, P. V. (1992). *Interventions with infants and parents: The theory and practice of previewing.* New York: John Wiley & Sons, Inc.

Widerstrom, A. H., Mowder, B. A., & Sandall, S. R. (1997). *Infant development and risk (2nd ed.).* Baltimore, MD: Paul H. Brookes.

Transdisciplinary Team Development: Using the Infant-Toddler Developmental Assessment

Shirley P. Roth, Joanna Erikson

PRESENTERS: Shirley P. Roth, Joanna Erikson

The Child Development Program of the National Children's Center serves over 200 children, birth through 5 years of age (with and without disabilities) and their families in center-based and home-based settings in Washington, DC. The professional staff providing clinical and educational services consists of physical therapists, occupational therapists, speech/language pathologists, psychologists, nurses, social workers, and teachers.

The goals of this project were to: (a) have a consistent, efficient, and accurate assessment of all children entering the program, (b) utilize an assessment tool that would have good reliability for indicating the need for further assessment in each domain, (c) foster and develop transdisciplinary skills among staff members, and (d) increase family participation in the assessment process.

The Infant-Toddler Development Assessment (IDA), an integrated clinical process, is organized into six phases:

1. Referral and Preinterview Data Gathering
2. Initial Parent Interview
3. Health Review
4. Developmental Observation and Assessment
5. Integration and Synthesis
6. Sharing Findings, Completion, and Report

The procedures provide a framework for the review and integration of data from multiple sources, as well as guidelines for team process and decision-making. The Provence Birth to Three Developmental Profile, the assessment tool used in phase four, devotes attention to affective domains as well as to more traditional skill areas. It includes eight domains: gross motor, fine motor, relationship to inanimate objects, language and communication, self-help, relationship to persons, emotions and feeling states, and coping.

Fifty-six professional staff members participated in a 2-day workshop that provided a comprehensive introduction to the IDA. The workshop included lectures, discussions, and video tapes and used a case study approach. The curriculum for the workshops follows the IDA procedures providing learning goals and competencies for each of the phases. The Infant-Toddler Development Assessment is based on a common core of knowledge for all practitioners. Following the workshops, all staff members had opportunities to implement the IDA procedures under supervision that included case discussion and review. In addition, paraprofessional staff were oriented to the new procedures so they could understand their role in the IDA process.

The Infant-Toddler Developmental Assessment tool is now utilized for each child entering the program functioning at the birth to 3 year age level. The IDA has consistently demonstrated when further assessments are needed in each domain. This has improved the quality of the program and ensured that children are referred to specific disciplines in a timely manner. Infant-Toddler Development Assessment teams, comprised of two to three persons of different disciplines, are performing assessments at each site location. This has enhanced the transdisciplinary process. Designated IDA leaders have been identified at each site and are available as resource persons for staff. All new staff are provided with a one and 1½ day workshop about the IDA process and how it is integrated into the Child Development Program.

A Home Intervention With Substance-Abusing Women: Effects on Mother-Infant Interaction at 6 Months

Maureen Schuler, Prasanna Nair

PRESENTER: Maureen Schuler

Little research has been done on the parenting abilities of substance-abusing mothers or on factors influencing these abilities (Singer, Garber, & Garber, 1991). Drug abuse among women has been found to be associated with a chaotic lifestyle (Regan, Ehrlich, & Finnegan, 1987) which may place the infant at double risk for a poor outcome due to prenatal drug exposure and poor parenting. Research indicates that a home intervention may lead to more positive parenting among a group of substance abusing mothers (Black, Nair, Kight, Wachtel, Roby, 7 Schuler, 1994).

The purpose of this study was to evaluate the effects of an intensive home intervention on mother-infant interaction with substance-abusing women and their infants. The data reported here is part of a longitudinal randomized study of an intensive home intervention with substance-abusing women (n=296) and their infants who were recruited from the neonatal unit of a university hospital. Mother/infant dyads were seen for evaluation visits at 2 weeks and 6, 12, 18, and 24 months. At the end of the 2-week visit, mother/infant dyads were randomly assigned to a control or intervention group. During the first year, intervention mothers had weekly home visits; control mothers had monthly home visits for tracking purposes only.

As part of the 6-month clinic visit, mother/infant dyads were video taped during a 10-minute feeding session. The mother-infant interaction was analyzed using modified versions of the rating scales from the schoolchildren and their families project (Cowan & Cowan, 1992). Coders were trained until they reach over 90% reliability and were blind to the group status and background of the dyads.

To reduce the number of maternal and infant variables, principal components analyses were run. Two maternal factors were created: positive maternal involvement and negative maternal involvement. Multivariate analysis of variance indicated no significant difference between control and intervention mothers in either positive or negative maternal involvement. Two infant factors were created: positive infant involvement and negative infant involvement. Multivariate analysis of variance indicated no significant difference between intervention and control infants in either positive or negative infant involvement.

These results must be interpreted with caution. It is possible that at such an early age (6 months) the infants are not mobile enough to represent a challenge to these substance-abusing women. Mothers in both the control and intervention groups were from the same substance-abusing, low SES population. Thus, the overall effects of poverty and continued maternal substance abuse may override the effects of an intervention on mother-infant interaction. More longitudinal research with substance-abusing women is needed to look beyond simple main effects to determine which infants and mothers are most at risk.

References

Black, M. M., Nair, P., Kight, C., Wachtel, R., Roby, P., & Schuler, M. (1994). Parenting and early development among children of drug-abusing women: Effects of home intervention. *Pediatrics, 94*, 440–448.

Cowan, P., & Cowan, C. (1992). *Schoolchildren and their families project.* University of California at Berkeley.

Regan, D., Ehrlich, S., & Finnegan, L. (1987). Infants of drug addicts: At risk for child abuse, neglect, and placement in foster care. *Neurotoxicology and Teratology, 9*, 315–319.

Singer, L., Garber, R., Kliegman, R. (1991). Neurobehavioral sequelae of fetal cocaine exposure. *Journal of Pediatrics, 119*, 667–672.

Contributions of Prenatal Drug Exposure and Caregiving Environment to Infant Development

Patricia A. McCullough, Christi A.C. Bergin

PRESENTER: Patricia A. McCullough

The proposed study addresses the relative contribution of prenatal drug exposure and caregiving environment to child development. In 1996, toxicology screens and self-report histories in one local, inner-city hospital indicated that 40% of obstetric patients were positive for drugs.

This study investigated: (a) the quality of attachment in drug-exposed infants and a matched non-drug-exposed comparison group, and (b) the relative contribution of prenatal drug exposure and caregiving environment to the quality of attachment. It was hypothesized that drug exposure is not as significant a contributor to development as quality of caregiving.

Subjects are part of an ongoing prenatally exposed infant study at a large, central city medical center. The sample is predominantly African American (86%), single (92%), and impoverished (93% receive Medicaid), with an average age of 27.7 years. Participation is voluntary. Subjects are 40 12-month-old infants who were prenatally exposed to drugs and their caregivers. A matched comparison group of 40 12-month-old infants not prenatally exposed to drugs and their mothers who delivered at the same hospital was established (matched for race, gender, gestation age, birth weight, age of mother, and parity). Four drugs are prevalent in the community: tobacco, alcohol, cocaine (crack), and marijuana.

The quality of attachment was measured using the Waters and Deane (1985) Attachment Q-sort, a 90-item observational system that permits an observer to describe individual differences in the functioning of the attachment system. Quality of mother-child play was determined using the Parent/Caregiver Involvement Scale (P/CIS; Farran, Kasari, Comfort, & Jay, 1986) from videotapes of feeding and play sessions at the OB/pediatric clinic site. Maternal sensitivity was measured by the Pederson and Moran Maternal Behavior Q-Set (1995).

A strength of this study is the availability of extensive data on prenatal drug exposure that includes quantity and trimester for all drugs to which the child was exposed using multiple methods: (a) prenatal toxicology screen, (b) self-report at each OB visit, (c) toxicology screen at delivery, and (d) report interview with the chemical dependency counselor (CDCCII).

Preliminary results are as follows. First, independent sample t tests found no significant difference in attachment security scores between prenatally drug-exposed and non-drug-exposed infants. Second, independent sample t tests found no significant differences in maternal sensitivity as measured either by the maternal Q-sort or the total impression score of the Parent/Caregiver Involvement Scale between mothers who exposed their infants to drugs prenatally and the comparison group mothers. Third, there were statistically significant correlations between attachment security and maternal sensitivity as measured both by the maternal Q-sort (r=.4833) and the total impression score of the Parent/Caregiver Involvement Scale (r=.4047). Finally, there were no significant zero order correlations between any of the drug use measures and attachment security. The strongest predictor of attachment security was maternal sensitivity (as measured by the maternal Q-sort). When maternal sensitivity was entered into a regression equation, the only other variable that contributed significantly to the prediction of attachment security was the amount of cocaine used during the 2nd trimester of pregnancy (marginally significant at p=.0488).

The significance of attachment security for early adaptation and development is carefully specified in theory and is supported by a body of correlational research. The significance of parental care for attachment security has equally strong theoretical foundations. Attachment theory is clear in assigning the primary role for determining attachment security to maternal caregiving (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Vondra, Shaw, & Kevenides,

1995). This study adds moderate empirical support to the growing number of studies indicating the relationship between quality of maternal care and infant attachment.

Across both groups of infants, those prenatally exposed to drugs and the comparison group, the only significant predictor of attachment security was sensitivity of maternal care. In the present study, we described maternal sensitivity in terms of contingent reaction to distress and maternal availability.

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment.* Hillsdale, NJ: Erlbaum.

Bowlby, J. (1969). *Attachment and loss, Vol.1.* New York: Basic Books.

Farran, D., Kasari, C., Comfort, M., & Jay, S. (1986). *Parent/Caregiver Involvement Scale Manual.* Unpublished manual, University of North Carolina.

Pederson, D., & Moran, G. (1995). A categorical description of infant-mother relationships in the home and its relation to Q-sort measures of infant-mother interaction. *Monographs of the Society for Research in Child Development, 60,* 111–132.

Vondra, J., Shaw, D., & Kevenides, M. (1995). Predicting infant attachment classification from multiple, contemporaneous measures of maternal care. *Infant Behavior and Development 18,* 415–425.

Waters, E., & Deane, K. E. (1985). Defining and assessing individual differences in attachment relationships: Q-methodology and the organization of behavior in infancy and early childhood. In I. B. E. Waters (Ed.), *Growing points of attachment theory and research, Vol. 50* (pp.41–65): Monographs of the Society for Research in Child Development.

Correlates of Attachment Security Among 10-Month-Olds in an Early Head Start Research Project

Lori A. Roggman, Lisa K. Boyce, Gina A. Cook, Vonda Jump

PRESENTERS: Lisa K. Boyce, Gina A. Cook

The formation of a primary attachment is one of the most important accomplishments in socio-emotional development during the latter part of an infant's first year of life (Bowlby, 1969). The security of infants' attachment to their mothers affects exploration of the world and later social competence (Benoit & Parker, 1994; Cohn, 1990). Thus, any project targeting infants, such as Early Head Start, will be concerned with factors that influence security of attachment.

Most attachment theorists say that the quality of attachment is an outgrowth of the history of mother-infant interaction to which both partners contribute. The infant contributes individual characteristics such as temperament. The mother contributes her parenting as affected by her attitudes about close relationships in general and her own parenting experience in particular.

Three variables are expected to contribute to infant attachment outcomes: infant temperament, maternal attitudes about close relationships, and parenting stress. Infants who are perceived to have a difficult temperament are more likely to be insecurely attached. In addition, mothers' working models of attachment, as reflected in relationship attitudes, may affect how they interact with others, including their infants, which affects the attachment relationship (Cox, Carey, Miller, & Kinney, 1997). Finally, high levels of parenting stress may negatively affect an infant's attachment relationship with the parent (Crockenberg, 1981; Jacobsen & Frye, 1991).

Researchers have not investigated parenting stress in relation to other correlates of attachment, such as temperament and relationship attitudes. Some research has indicated that parents'

relationship attitudes do influence infants' attachment (Posada, Waters, Crowell, & Lay, 1995), but other research has found no relation (Cox et al., 1997). The purpose of the current research is to examine two pathways to the formation of parent-infant attachment and parental attitudes about close relationships and perceptions of infant temperament, and to explore how those pathways may be mediated by parenting stress.

Participants included 49 low-income mothers from both the program and comparison groups of the Utah Early Head Start (EHS) Research Project. Forty-seven of the mothers were Caucasian and two were Hispanic. Data were collected in the families' home at the time of the infant's 10-month assessment as scheduled by the EHS research team. The measures included: the Parenting Stress Index/Short Form (Abidin, 1990), the Attachment Q-set (Waters, 1987), the Relationship Attitudes Scale (Simpson, Rholes, & Nelligan, 1992), and the EASI (Buss & Plomin, 1975).

A series of regression models were used to explore relations among mothers' perceptions of infant temperament (negative emotionality), parent relationship attitudes, parenting stress, and infant attachment security. It is proposed that parenting stress mediates the relations of parent relationship attitudes and infant emotionality with infant attachment outcomes.

The path models suggest that when infants are 10 months old, mothers' perceptions of infant emotionality contribute more to infant attachment security than parent relationship attitudes do. The total "effect" of emotionality on attachment increases as it is mediated by parenting stress. Furthermore, parents with more ambivalence toward close relationships appear to perceive their infants as more emotional and to experience parenting as more stressful.

References

Abidin, R. R. (1990). *Parenting stress inventory/Short form.* Virginia: Pediatric Psychology Press.

Benoit, D., & Parker, K. C. H. (1994). Stability and transmission of attachment across three generations. *Child Development, 65,* 1444–1456.

Bowlby, J. (1969). *Attachment and loss: Vol. 1.* New York: Basic.

Buss, A. H., & Plomin, R. (1975). *A temperament theory of personality development.* New York: Wiley.

Cox, S. M., Carey, S. A., Miller, B. R. E., & Kinney, L.M. (1997). Correlates of interaction and attachment in a high-risk preterm sample: Maternal past history, emotional availability, and strange situation behavior. Unpublished manuscript.

Crockenberg, S. B. (1981). Infant irritability, mother responsiveness, and social support influences on the security of infant-mother attachment. *Child Development, 52,* 857–865.

Jacobsen, S. W., & Frey, K.F. (1991). Effect of maternal social support on attachment: Experimental evidence. *Child Development, 62,* 572–582.

Posada, G., Walters, E., Crowell, J. A., & Lay, K. L. (1995). Is it easier to use a secure mother as a secure base? Attachment q-sort correlates of the adult attachment interview. In E. Water, B. E. Vaughn, G. Posada, & K. Kondo-Ikemura (Eds.), New growing points of attachment theory and research. *Monographs of the Society for Research in Child Development, 60,* (2–3, Serial No. 244), 133–145.

Simpson, J. A., Rholes, W. S., & Nelligan, J. S. (1992). Support seeking and support giving within couples in an anxiety-provoking situation: The role of attachment styles. *Journal of Personality and Social Psychology, 63,* 434–446.

Waters, E. (1987). *Attachment Behavior Q-Set* (Revision 3.0). Unpublished instrument, State University of New York at Stony Brook, Department of Psychology.

The Chicago Health Connection Doula Project: Support During a Critical Period for Adolescent Mothers and Their Infants

Susan Altfeld, Judy Teibloom-Mishkin

PRESENTER: Susan Altfeld

Despite a recent decline in the adolescent birth rate, more than half a million adolescent women give birth in the United States each year (Ventura, Peters, Martin, & Maurer, 1997). Interventions to improve the health and well-being of adolescent mothers and babies and to reduce health care costs associated with these births are potentially valuable strategies for programs offering early intervention services.

Several existing research studies on the effect of "doulas," or childbirth support providers during labor and delivery, have demonstrated that doula involvement was associated with shorter duration of labor, fewer medical interventions and complications, lower cesarean section rates, and increased likelihood of breastfeeding (Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980; Klaus, Kennell, Robertson, & Urrutia 1986; Hofmeyr, Nikodem, Wolman, Chalmers, & Kramer, 1991; Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1996).

In 1996, the Chicago Health Connection, in collaboration with the Ounce of Prevention Fund and three Chicago community-based organizations, began a 4-year project in perinatal support for adolescents in three low-income communities. The Doula Project was nested in existing longer-term support programs for pregnant and parenting adolescents at these sites. The Chicago Health Connection received funding to train and employ a cadre of paraprofessional women as doulas to provide support for teen mothers through the partner agencies.

Doulas were recruited from among agency staff and volunteers as well as through churches, schools, and child care settings. The Chicago Health Connection has more than a decade of experience in training low-income women and health professionals who serve them to promote breastfeeding, child immunizations, and other health-enhancing strategies. Their training model has incorporated elements from both Adult Learning Theory and the "Empowerment Education" philosophy and techniques from Paulo Freire. There was no formal education requirement for the doulas although literacy is necessary.

The classical core doula intervention, as reflected in previous research, is support during labor and delivery. This study has built on existing knowledge and experience by focusing on a teen population and extending doula involvement from prenatal education during the last trimester of pregnancy to home visits during the first 3 months of the baby's life.

In the first 15 months of the Doula Project, there have been 87 births. The cesarean section rate for participants is 5.75%, significantly lower than the rate of 14.7% for women in the U.S. under the age of 20 (Curtin, 1997). The initiation of breastfeeding rate for Doula Project participants is also noteworthy: 80% compared with the national teen breastfeeding rate of 43% (Ryan, 1997).

The Doula Project addresses the issues posed by adolescent childbearing with an approach that improves care for an at-risk population by developing trusting, supportive relationships at a critical moment in the development of the family. Its focus on supporting and training community leadership taps powerful indigenous resources and provides a process for growth and professional development for natural leaders in low-income communities.

References

Abma, J. C., Chandra, A., Mosher, W. D., Peterson, L., & Piccinino, L. (1997). Fertility, family planning, and women's health: New data from the 1995 National Survey of Family Growth. *Vital and Health Statistics, 23*(19). Hyattsville, MD: National Center for Health Statistics.

Curtin, S. C. (1997). Rates of cesarean birth and vaginal birth after previous cesarean, 1991–1995. *Monthly Vital Statistics Report, 45*(11), supp. 3. Hyattsville, MD: National Center for Health Statistics.

Hofmeyr, G. J., Nikodem, V. C., Wolman, W. L., Chalmers, B. E., & Kramer, T. (1991). Companionship to modify the clinical birth environment: Effects on progress and perceptions of labor, and breastfeeding. *British Journal of Obstetrics and Gynaecology, 98*(8), 756–64.

Klaus, M. H., Kennell, J. H., Robertson, S., & Urrutia, J. (1986). The effects of social support during parturition on maternal and infant morbidity. *British Medical Journal 293*, 597–600.

Kennell, J., Klaus, M., McGrath, S., Robertson, S., & Hinkley, C. (1991). Continuous emotional support during labor in a US hospital: A randomized controlled trial. *Journal of the American Medical Association 265*(17).

Ryan, A. S. (1997). The resurgence of breastfeeding in the United States. *Pediatrics 99*(4), e12.

Sosa, R., Kennell, J., Klaus, M., Robertson, S., & Urrutia, J. (1980). The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *The New England Journal of Medicine 303*(11), 597–600.

Ventura, S. J., Peters, K. D., Martin, J. A., & Maurer, J. D. (1997). *Births and deaths: United States 1996 Monthly Vital Statistics Report, 46*(1), supp. 2. Hyattsville, MD: National Center for Health Statistics.

Zhang, J., Bernasko, J. W., Leybovich, E., Fahs, M., & Hatch, M. C. (1997). Continuous labor support from labor attendant for primiparous women: A meta-analysis. *Obstetrics and Gynecology, 88*(4, part 2), 739–744.

Early Identification of Infants at Double Risk for Developmental Delay

Hallie E. Savage

PRESENTER: Hallie E. Savage

Cleft lip and palate is one of the most frequent congenital anomalies identified at birth, the incidence of which in the Caucasian population is approximately 1 in 60 live births, with the rate higher in Asian groups and lower in African-American groups (Shprintzen & Bardach, 1995). This infant population has medical diagnoses (e.g., congenital malformations, associated anomalies, etc.) and environmental risk factors that interact in a synergistic fashion and place them at double risk for developmental delay. According to cleft type, approximately 75% of the infants born with clefts exhibit a cleft of the lip which affects the infant's facial appearance. Clefts result in a wide variation of the structural and functional deficits, that is, facial disfigurement, disruptions in feeding, middle ear disease and associated fluctuating hearing loss. Associated anomalies may also be present with the cleft, particularly isolated cleft palate, that imply increased biological risk factors for developmental delay.

Developmental assessment of this infant population reflects a multifactored analysis of the infant's environment: the effect of infant facial appearance on adult expectations for development, the occurrence of early surgical intervention, and the accompanying infant pain and trauma (Savage, Neiman & Reuter, 1994). Research on infant attractiveness would imply the presence of visible stigmata of the infant with cleft lip and the presence of a congenital anomaly function as a salient and powerful cue in adult expectations for development, and, consequently, on developmental skill acquisition (Savage, 1997). The family stress manifested along an age continuum from the traumatic birth experiences to the occurrence of early surgical intervention and associated hospitalization potentially have an additive effect on stress manifested within the family unit that mediates early environmental input for developmental experience. Collectively, this clinical research provides a strong rationale for early identification of infants with clefts.

To describe the developmental impact of these early events, assessment data was obtained on 186 infants and toddlers (Neiman & Savage, 1997). Developmental assessment measures were selected based on the need for a fine-grained description of all developmental domains.

Developmental status was described by the Kent Infant Development Scale and the Minnesota Child Developmental Inventory, both caregiver report measures. The results revealed that 5-month-old infants exhibited "at-risk or delayed" development. By 13 months and 25 months, developmental resilience is apparent as reflected by their full-scale scores, depending on the cleft type. However, developmental patterns for language, motor, and self-help skills were more vulnerable to delay when compared to other domains.

The development of infants with clefts is synergistically linked to a complex interaction of biological factors associated with the presence of a cleft and multiple environmental factors. Despite the surgeries and hospitalizations, developmental progress can be remarkably resilient. These developmental patterns are discussed relative to the events surrounding family caregiving modifications including surgery, middle ear problems, and feeding difficulty. Recommendations are discussed for an early assessment schedule and strategies for family counseling during the first 3 years of life.

References

Neiman, G., & Savage, H. (1997). Development of infants and toddlers with clefts from birth to three years of age. *Cleft Palate-Craniofacial Journal, 34*(3):218–225.

Savage, H. (1997). An early intervention guide to infants born with clefts. *Infant-Toddler Intervention, Vol. 7* (4): 271–284.

Savage, H., Neiman, G., & Reuter, J. (1994). Developmental perspective on assessment of infants with clefts. *Infant Toddler Intervention 4*(3): 221–234.

Savage, H., & Neiman, G. (1991). Maternal responses to an infant with a cleft lip and palate. *Infant Toddler Intervention, 1*(2).

Shprintzen, R., & Bardach, J. (1995). *Cleft palate speech management: A multidisciplinary approach.* St. Louis, MO: Mosby.

Similarities and Differences in the Family Routines of an Ethnically Diverse Group of Early Head Start Research Families

Lorraine F. Kubicek, Robert N. Emde

PRESENTERS: Lorraine F. Kubicek, Robert N. Emde

Family routines are patterned interactions that occur with predictable regularity in the course of everyday living. Routines help to organize family life, reinforce family identity, and provide members with a shared sense of belonging (Wolin & Bennett, 1984). Research suggests that adherence to routines contributes to family stability and continuity, thereby acting as a buffer during normative transitions such as marriage and parenthood (Fiese, Hooker, Kotary, & Schwagler, 1993) and serving a protective function against risk factors such as alcoholism and divorce (Boyce, Jensen, James, & Peacock, 1983). Moreover, routines provide the context for much of early childhood socialization (Reiss, 1981; Rogoff, Mistry, Goncu, & Mosier, 1993).

Although routines are considered a universal attribute of family life, few details are known about the actual day-to-day practices of families with young children, particularly those with low incomes. Two studies that have focused on low-income Head Start preschoolers point to the beneficial effects of family routines on child social and cognitive outcomes (Churchill & Stoneman, 1997; Keltner, 1990). These results suggest a promising area in need of more systematic research aimed at identifying strengths in such routines, as well as documenting areas of impoverishment and difficulty so that culturally appropriate interventions can be developed.

Subjects were 6 women ranging in age from 20 to 24 years who were randomly selected from

each of the three predominant ethnic groups participating in this study (African American, Caucasian, and Hispanic). All of these low-income mothers were recruited for a sample that will eventually include 300 Early Head Start research participants, many of whom are single parents. The mothers were randomly assigned to either an Early Head Start program (based at one of the two national research sites for Early Head Start in the Denver area) or to a research comparison group.

During a playroom laboratory visit when their infant was 8 months old, mothers were videotaped taking part in an interview in which they were asked to describe, in detail, their activities during the previous 24 hours. We were particularly interested in where their infant was throughout the day and probed for specific caretaking routines such as naptime, feedings, bathtime, dressing, and diaper changes. At the end of the interview, the mother was asked whether or not the previous day was a "typical" day for her and if not, how it was different. The interview usually lasted approximately 15 minutes. Our impression thus far is that mothers enjoy the opportunity to talk about how they spend their day.

Results from this exploratory study suggest that this interview is an effective technique for assessing meaningful variation in the daily routines of an ethnically diverse group of families. Differences were evident in both the number and kind of maternal and caretaking routines mothers followed. Of particular interest were differences in the extent to which mothers elaborate their caretaking routines and use these as opportunities for social and emotional engagement. We plan eventually to explore the relation between the practice of family routines in this sample and a number of outcome assessments in toddlerhood.

References

Boyce, W. T., Jensen, E. W., James, S. A., & Peacock, J. L. (1983). The family routines inventory: Theoretical origins. *Social Science and Medicine, 17*(4), 193–200.

Churchill, S. L., & Stoneman, Z. (April, 1991). *Family routines and temperament as a predictor of child outcomes: Differences by sex of child.* Poster presented at the biennial meeting of the Society for Research in Child Development, Washington, DC.

Fiese, B. H., Hooker, K. A., Kotary, L., & Schwagler, J. (1993). Family rituals in the early stages of parenthood. *Journal of Marriage and the Family, 55*, 663–642.

Keltner, B. (1990). Family characteristics of preschool social competence among Black children in a Head Start program. *Child Psychiatry and Human Development, 21*(2), 95–108.

Reiss, D. (1981). *The family's construction of reality.* Cambridge: Harvard University Press.

Rogoff, B., Mistry, J., Goncu, A., & Mosier, C. (1993). Guided participation in cultural activity by toddlers and caregivers. *Monographs of the Society for Research in Child Development, 58* (8, Serial No. 236).

Wolin, S. J., & Bennett, L. A. (1984). Family rituals. *Family Process, 23*, 401–420.

Early Identification of At-Risk Children

Beverly Mulvihill, Sandra Cluett, Laurie Sullivan

PRESENTERS: Beverly Mulvihill, Sandra Cluett, Laurie Sullivan

Birth certificates were examined to identify risk factors that may later predict special education placements. Children whose mothers had less than high school education were more than three times as likely as children whose mothers finished high school to be diagnosed with mild or moderate mental retardation, 2½ times as likely to be emotionally conflicted, and had a 60% greater risk of speech and language difficulties.

(Abstract from original proposal; paper summary not received for publication.)

Measures

Assessment Profile: From Checklist to Scale

Annette Sibley, Martha S. Abbott-Shim, John Neel

PRESENTER: Martha S. Abbott-Shim

The aim of this study was to develop empirically sound scales that provide global measures of program quality from a comprehensive formative evaluation checklist. The Assessment Profile for Early Childhood Programs is an exhaustive inventory of classroom practices and includes 147 items intended to be used for descriptive purposes. Initial checklist development involved a comprehensive review of the early childhood literature, child development literature, and teacher training materials. To establish content validity, the checklists were reviewed by more than 50 early childhood professionals including trainers, program administrators, teachers, resource and referral staff, and professors of early childhood education. The original checklists were field tested in 90 child care programs in Atlanta, Georgia. Finally, the checklists were cross-referenced with the accreditation criteria of the National Association for the Education of Young Children. These accreditation criteria were established in 1985 and represent a national, professional consensus on the standards of high quality and developmentally appropriate practices for early childhood programs.

The development of a shorter, research version of the Assessment Profile began with a traditional item analysis. Data were compiled from over 2,000 classrooms in research studies using the Assessment Profile. Items were selected to give a range of difficulty from .01 to .90, with some exceptions. Items with good discrimination indices (>.45) were abundant, but items with a proportion of successes in the range of .10 to .90 were not as abundant. Some of the original 147 checklist items represented minimal requirements for classroom practices. Consequently, there were relatively few classrooms that did not succeed on these items. Accordingly, a classroom that did not provide one of these items was probably a lower quality classroom.

A factor analysis for each of the six domains was performed to determine if the items were consistent and sufficiently unidimensional to permit use of an IRT model. The Health & Safety domain did not account for sufficient variance to form an adequate scale; thus a scale was not formed for the Health & Safety domain. The eigenvalues for the other five domains accounted for greater than 25% of the variance, which is the limit that Reckase implied as necessary for essential unidimensionality.

Five scales were thus formed by selecting 12 items for each scale from the original items in the Assessment Profile checklist. These items were selected to obtain discrimination between high and low abilities on the scales. This discrimination is reflected in the test information curves. As critical questions about the quality of classroom practices and its relationship to child outcomes continue to be debated, the technology of measuring quality gains increasing importance. The use of the IRT to transform the Assessment Profile for Early Childhood Programs from a checklist to a scale is a unique application. These analysis have shown that the Assessment Profile, Research Version, is a useful set of scales for measuring the quality, and therefore developmental appropriateness, of teaching practices.

Assessing Program Quality With the Early Childhood Environment Rating Scale—Revised (ECERS-R)

Thelma Harms, Richard M. Clifford, Debby Cryer

PRESENTER: Thelma Harms

This poster session introduced the ECERS-R, a thoroughly revised version of the Early Childhood Environment Rating Scale. Designed for use in preschool, Head Start, kindergarten, and child care classrooms serving children 2½ through 5 years of age, the ECERS-R can be used by program directors for supervision and program improvement, by teaching staff for self-assessment, by agency staff for monitoring, and in teacher training programs. The established reliability and validity of the scale make it particularly useful for research and program evaluation.

The original version of the ECERS has been widely used as a global quality measure in such large scale studies as the National Child Care Staffing Study, the Cost, Quality and Outcomes Study, and the current FACES study. After 17 years of extensive use in the United States and abroad, a revision, the ECERS-R, is now available from Teachers College Press (ISBN: 08077-3751-8).

The new ECERS-R has been expanded to 43 items and includes many improvements that will make this widely used resource even more valuable to early childhood educators. Examples of new items include: (a) interaction items, such as staff-child interaction, interactions among children, and discipline, (b) additional curriculum items such as nature/science; math/number; use of TV, video, and/or computers; and promoting acceptance of diversity, (c) health and safety items, (d) more inclusive and culturally sensitive indicators and examples for many items, and (e) more items focusing on staff needs.

Each of the items is expressed as a 7-point scale, with indicators for 1 (inadequate), 3 (minimal), 5 (good), and 7 (excellent). Notes for clarification and questions are included for selected items. The basic orientation to quality in the ECERS-R is in keeping with NAEYC accreditation, CDA, and the Head Start philosophy. The ECERS-R has been thoroughly field tested to assure its reliability and its applicability in inclusive classrooms and with diverse populations.

The 43 items of the ECERS-R are organized under seven categories: Space & Furnishings, Personal Care routines, Language-Reasoning, Activities, Interaction, Program Structure and Parents and Staff. The format of each item has been revised to permit scoring of each indicator. The scoring instructions have been made consistent with the scoring convention used in the other scales in this series: the Infant-Toddler Environment Rating Scale (Harms, Cryer & Clifford, 1990), the Family Day Care Rating Scale (Harms & Clifford, 1989), and the School Age Care Environment Rating Scale (Harms, Jacobs & White, 1996).

An introductory section gives detailed information about the rationale of the ECERS-R, the process of revision, and the reliability and validity of the scale. Full instructions for administration and scoring as well as a Score Sheet and Profile that may be photocopied, are included with the scale.

References

Harms, T., & Clifford, R. M. (1989). *Family Day Care Rating Scale.* New York: Teachers College Press.

Harms, T., Cryer, D., & Clifford, R. M. (1990). *Infant/Toddler Environment Rating Scale.* New York: Teachers College Press.

Harms, T. Jacobs, E., & White, D. (1996). *School Age Care Environment Rating Scale.* New York: Teachers College Press.

Assessing Interactive Play in Kindergarten: The Penn Interactive Peer Play Scale

Virginia R. Hampton, John W. Fantuzzo, Patricia H. Manz

PRESENTERS: Virginia R. Hampton, Patricia H. Manz, John W. Fantuzzo

Establishing effective interactions with peers is an important competency to acquire in order to enhance children's social and academic success. For young children, play is a primary context for developing competency with peers. Efforts to promote this competency are strengthened by parent-school collaborations, which create continuity between the home and school environments. Furthermore, continuity between Head Start and kindergarten helps children transition to elementary school.

To inform the development of interactive peer play skills, quality measures of this competency are needed. These measures must relate to developmentally appropriate play competencies. Parallel parent and teacher versions are necessary because they provide a cross-informant assessment of children's competencies. Furthermore, measures should have parallel versions for preschool and kindergarten to facilitate continuity of assessment and intervention between the two settings.

In response to the need for measurement in early childhood, the Penn Interactive Peer Play Scale System (PIPPS) was developed. The PIPPS consists of rating scales for parents and teachers to assess the interactive peer play behavior of ethnic minority, low-income children. Both versions contain 32 identical items to assess play competencies that differentiate children who demonstrate positive peer relationships from children who have difficulties with peer interactions. The teacher version assesses children's play activities in the classroom and at school, whereas the parent version examines play at home and in the neighborhood. Each version has three factors: Play Interaction, Play Disruption, and Play Disconnection. Analyses indicate congruence of factors between the two versions. Concurrent validity has also been established.

Research is needed to examine the validity of the PIPPS in kindergarten to assist with continuity during the transition from preschool to kindergarten. The purpose of this study was to (a) validate the kindergarten version of the PIPPS, (b) examine the relationship between the parent and teacher versions, and (c) examine the relationship between the preschool and kindergarten versions. The participants were 438 ethnic minority, low-income children enrolled in kindergarten in a large urban setting. A series of common factor analyses were conducted to assess the construct validity of the parent and teacher versions. With both the parent and teacher versions, the analyses replicated the three-factor solution of the preschool version, thereby supporting the scale's three underlying constructs: Play Interaction, Play Disruption, and Play Disconnection. The results also supported the congruence of factors between the two versions, indicating that the parent and teacher versions measure congruent constructs. Furthermore, the factors of the kindergarten version matched those of the preschool version.

The validation of the parent and teacher versions of the kindergarten PIPPS indicates its usefulness for identifying interactive play behaviors of low-income, ethnic minority, urban children in kindergarten. Furthermore, the PIPPS can assess children's play across preschool and kindergarten, thereby facilitating assessment and intervention during this transition. The PIPPS obtains information about the same constructs of interactive peer play, from both teachers and parents, for preschool and kindergarten children at school and at home. These findings represent a promising approach to providing quality assessment measures to ensure quality practices.

Development and Validation of the Parent Version of the Penn Interactive Peer Play Scale

Julia Mendez, Megan Noone, Erin Tighe
PRESENTERS: Julia Mendez, Megan Noone, Erin Tighe

In formulating program improvements, Head Start recognizes that children from low-income families, especially in densely populated urban areas, are not only experiencing deep poverty, but also the erosion of family and of neighborhood social structures. In light of the growing stress on families, Head Start has revised its performance standards to further promote the involvement of parents in genuine partnerships with Head Start teachers in order to enhance children's development of social competencies. For preschool children, demonstrating play with peers is an essential developmental task that serves as a primary context for the acquisition of important social competencies (Cicchetti & Lynch, 1993).

To maximize the effectiveness of social competence intervention, partnership efforts with families are essential. This is particularly important for children from low-income and culturally diverse backgrounds who often face heightened challenges as they enter school. These children are at greater risk for disparity between their home and school environments. Greater continuity between home and school can be achieved by having preschool programs promote parent involvement in education. One way to gather information from parents regarding children's competencies is to use psychometrically sound parent-rating instruments. Ethnological methods have been recommended for research with minority children because they rely upon inductive description and categorization of behaviors. These methods avoid preconceived, majority-based theories of behavior and development.

In addressing the need for a congruent assessment system for both parents and teachers, researchers, in collaboration with Head Start teachers and parents, developed the Penn Interactive Peer Play Scale (PIPPS). Using ethnological methodology, the PIPPS was developed to assess social competence among children living in impoverished, urban environments at high risk for discontinuity between home and school. By incorporating teacher and parent input into each stage of this measures development, researchers intended to heighten their own sensitivity to the meaningful cultural expressions contained within children's play. The teacher and parent versions contain 32 identical items designed to assess competencies within play that can differentiate these children who demonstrate positive peer relationships from those who are less successful with peers. The teacher version yields a report of play activities at school and in the classroom, while the parent version assesses play at home and in the neighborhood. The present study examined the parent PIPPS' construct validity as well as the overlap between parent and teacher factors. Two hundred and ninety-seven preschool children enrolled in a large, central-city Head Start program participated in this study.

The teacher version of the PIPPS, used to establish validity for the PIPPS parent version, demonstrated three reliable constructs of peer play: Play Interaction, Play Disruption and Play Disconnection. Exploratory factor analyses for the parent PIPPS revealed the same three-factor structure as did factor analyses of the teacher version. Comparisons between the teacher and parent factor structures supported the factorial congruence between versions. Bivariate and multivariate correlational analyses conducted to further assess the parent-teacher relationship showed significant correlations between each corresponding factor for the parent and teacher versions. Canonical variance analysis corroborated our findings of three PIPPS dimensions across both parent and teacher versions.

An Investigation of the Clinical Utility of the House-Tree-Person Projective Drawings in the Psychological Evaluation of Child Sexual Abuse

Laura Palmer, Anne Farrar, Maria Valle, Nouriman Ghahary, Michael Panella, Donna DeGraw, Karin Mellina

PRESENTERS: Anne Farrar, Nouriman Ghahary, Laura Palmer, Michael Panella, Maria Valle

This is an investigation of the clinical validity and utility of the House-Tree-Person (HTP) projective drawings in the psychological assessment of child sexual abuse. The National Center on Child Abuse and Neglect (1988) estimates that approximately 1% of children are sexually abused in the United States each year. The working estimate of prevalence suggests that at least 20% of American women and 5% to 10% of American men have experienced some form of sexual abuse as children. There is also the concern of false allegations leading to undue prosecutions and incarcerations of those accused. There are multiple factors that can lead to false allegations, including inexperienced evaluators, emotional influence of vindictive parents, psychopathology, and lack of reliable and valid standardized measures. Of these, clinicians have control over the methodology endorsed in evaluations.

Despite their popularity, projective drawing techniques have been the subject of constant controversy (Hagood, 1992). Research on projective drawings has been of generally poor quality, which has prevented any conclusive statements about their clinical validity (Van Hutton, 1994). It is only when the evaluation methodology has more rigor and standardization that the clinician is afforded more certainty.

For this study, HTP drawings were collected archivally from a clinical sample of sexually abused children (n=47) and a same-age comparison sample (n=82). The investigators' query was whether a standardized format for the scoring of the House-Tree-Person drawings could differentiate between sexually abused and nonsexually abused children. The protocols were scored using a published standardized method and analyzed using discriminant function analysis. The inclusion criteria for the clinical participants included children between the ages of 4 years 6 months through 17 years 5 months with a documented history of child sexual abuse. The clinical participants were recruited through the Rapid Intervention Team (RIT) and Children of Rape Trauma Syndrome Clinic (CORTS), two programs administered by the Children's Hospital of Newark, New Jersey. The comparative participants (n=82) were recruited from two local churches in Passaic and Essex counties and the noninvolved siblings of the clinical sample. The two groups were comparable for age.

The four HTP index scores and total HTP index scores were entered into a discriminant function analysis as predictors of membership in two groups, clinical or comparison. None of the predictors was significant. Only one indicator was identified that discriminated between groups, which was omission of hands (p=.038). This indicator occurred at a much higher frequency in the clinical sample. A post hoc ANOVA designed to assess the impact of increasing severity of trauma on the total HTP score was also found to be insignificant (p=.488). This research would caution evaluators to never use projective measures without an accompanying inquiry in the evaluation of child sexual abuse and never to the exclusion of standardized behavioral and emotional measures.

References

Hagood, M. H. (1992). Diagnosis or dilemma: Drawings of sexually abused children. *British Journal of Projective Psychology, 37*, 22–33.

National Center on Child Abuse and Neglect. (1988). *Study of National Incidents and Prevalence on Child Abuse and Neglect.* Washington, DC: Government Printing Office.

Van Hutton, V. (1994). *House-Tree-Person and Draw-A-Person as measures of abuse in children: A quantitative scoring system.* Odessa, FL: Psychological Assessment Resources.

Computer-Presented Parenting Dilemmas: Measuring Hostile Family Climate

Laura Hubbs-Tait, Rex E. Culp, Anne McDonald Culp, Huei-Juang Starost

PRESENTERS: Laura Hubbs-Tait, Anne McDonald Culp, Rex E. Culp, Charles Hare

Head Start staff and policy makers have called for greater attention to the problems associated with family conflict and violence that children enrolled in Head Start may experience (e.g., Piotrkowski, Collins, Knitzer, & Robinson, 1994; Takanishi & DeLeon, 1994). To a great extent, the impact of family conflict on children has been assessed among children not attending Head Start. That research literature provides a consistent picture of the negative impact of family conflict on children. However, hostility within the family does not have to escalate into open conflict for there to be a negative impact on children. Harsh discipline, particularly intense physical punishment, has been associated with stable high aggression among kindergarten (Strassberg, Dodge, Pettit, & Bates, 1994) and 2- to 8-year-old children (Kingston & Prior, 1995), and poor academic performance, particularly low classroom grades (Wentzel, Feldman, & Weinberger, 1991). Hostility may be a personality characteristic (Buss & Perry, 1992), characterize dyadic interactions (Holden & Ritchie, 1991), or pervade the family system (McCloskey, Figueredo, & Koss, 1995). The purpose of the study was to examine the construct and criterion validity of a measure of hostile climate in families of Head Start children.

Participants were 167 4-year-old children attending Head Start in 1995–1996 or 1996–1997 and their primary caregivers (162 mothers, 2 stepmothers, and 3 grandmothers with custody). Primary caregivers ranged in age from 19 to 54 years (M=29.4). Twenty percent did not have a high school diploma, 36% were high school graduates, 11% were vocational-technical graduates, 28% had some college, and 5% were college graduates. Thirteen percent received welfare (AFDC or TANF), 68% received other forms of public assistance (e.g., food stamps, WIC), and 18% received no assistance. The ethnicity of the primary caregivers was as follows: 74% Caucasian; 18% Native American; 3% African American; 4% Latino; and 1% multiethnic. Many children were multiethnic. In this report, we deem the child as belonging to an ethnicity of color, if either biological parent's ethnicity was of color. Thus, children's ethnicity was as follows: 56% Caucasian; 29% Native American; 7% African American; 5% Latino; and 3% triethnic.

In the fall, primary caregivers completed the Aggression Questionnaire (AQ; Buss & Perry, 1992), a measure of hostile personality with four subscales: hostility, anger, verbal aggression, and physical aggression. They also completed the Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984), with two subscales assessing hostile parenting behavior: belief in physical punishment and lack of empathy (*all alphas*>.75).

In the spring, primary caregivers completed the Computer-Presented Parenting Dilemmas (CPPD), an interactive computer assessment modified from Holden's Computer Presented Social Situations (Holden & Ritchie, 1991). Three CPPD vignettes assess hostile family climate. Included as named family members in the vignettes are the Head Start child and whomever the mother has named as her partner (may be an extended family member). In one story, the Head Start child has fallen down outside and the mother's partner is with the child. Questions ask the mother how her partner would respond to the child's distress and include such responses as "yell at child," "get mad at me," and "prevent me from comforting child." In the second story, the mother's partner cannot find the car keys and shouts at her that she lost them. Questions ask how the mother responds (e.g., get mad, yell). In the third, the argument over keys continues with the partner finally hitting the mother and the child getting very upset. Questions ask how frequently this happens and how the mother responds (yell, hit, comfort child, take the child and leave). Principal components analysis revealed a six-factor solution that explained 83% of the variance.

At the same time as mothers responded to the CPPD, children completed Harter's Pictorial

Scale of Perceived Competence and Social Acceptance for Young Children (Pictorial PCS; Harter & Pike, 1984). Within 3 weeks, Head Start teachers completed Howes' (1988) Rating Scale for Social Competence with Peers (Hesitant, Difficult and Sociable subscales; *all alphas*>.70) and the Preschool Behavior Questionnaire (PBQ; Behar, 1977; Aggressive, Hyperactive and Anxious subscales; *all alphas*>.70).

Factor analysis revealed that responses to Harter's Pictorial PCS did not comprise the traditional four factors. Because the focus of the current report is on the CPPD, the complete results of our factor analysis of the Harter measure will not be reported. Two factors are relevant: a Maternal Acceptance factor consisting of "mom reads to you," "mom plays with you," "mom talks to you," and "eats dinner at friends" (*alpha*=.65) and a Friends factor consisting of "has lots of friends," "has friends to play with," and "has friends on playground" (*alpha*=.65).

Prior to calculating correlations between CPPD factors and questionnaire measures, correlations among CPPD factors were computed. Partner Coercive Control and Partner Affection and Empathy were highly correlated (r=-.69). Thus, these two factors were combined with coercive items reversed so that the factor reflected affection and empathy (*alpha*=.88).

The correlation matrix supports the validity of Reciprocal Violence because it is most highly correlated with maternal physical aggression. Whereas Maternal Conflict is significantly correlated only with mothers' hostility, Maternal Protection and Comfort is significantly inversely correlated with maternal hostility, physical punishment, and lack of empathy. Partner Affection and Empathy is significantly inversely correlated with all measures of hostile personality and parenting, suggesting that this factor reflects lack of hostility throughout the family.

If CPPD factors reflect hostile family climate, then they should be related meaningfully to measures of children's social competence. Reciprocal Violence was negatively correlated with three measures of social competence: Sociable scores (r=-.25, p<.01), the Friends factor (r=-.21, p<.05), and the Maternal Acceptance factor (r=-.21, p<.05). Maternal Conflict was correlated with Difficult (r=.19, p<.05) and Aggressive scores (r=.19, p<.05). Partner Affection and Empathy was correlated with Maternal Acceptance (r=.18, p<.05).

Regressions confirmed that both Reciprocal Violence (*beta*=-.20, p<.05) and Partner Affection and Empathy (*beta*=.21, p<.05) contributed to the prediction of the Maternal Acceptance factor ($R2$=.09, p<.01). Reciprocal Violence also explained significant incremental variance in Sociable scores ($R2$=.08, p<.01) beyond that already explained by maternal lack of empathy ($R2$=.07, p<.01).

These results support the validity of the CPPD as a measure of hostile family climate. It is important to note that the CPPD factors not only are related to measures of maternal personality and parenting, but also predict children's social competence and behavior problems. Particularly noteworthy is the fact that 9% of the variance in children's ratings of their acceptance by their mothers is explained by reciprocal hitting between the mother and her partner and by the mother's partner's affection and empathy for the child. This relationship means that children's perceptions of their mother's acceptance of them can be accounted for in part by how their mother's partner treats them as well as by the degree of mutual hitting between mother and her partner. Neither of these two factors relate directly to the mother's own treatment of her child, underscoring how important the climate of the family as a whole is in the development of a child's perception of his/her relationship with mother.

The current results underscore the importance of parenting programs for Head Start parents designed to reduce family conflicts and violence. Mutual hitting between mother and partner explained significant variance both in children's perceptions of their acceptance by mothers and in teacher's ratings of the children's sociability in the Head Start classroom. Thus, by the end of their 4-year-old year in Head Start, children's classroom behavior was significantly impacted by the violence in the home. Note that the relationship between Partner Affection and Empathy (and its negative pole, Partner Coercive Control) and maternal acceptance underscores the fact that hostility does not have to escalate to violence for children to be affected. Such a finding

suggests a need for parenting programs in Head Start that help parents to recognize unhealthy levels of hostility and to obtain help or treatment prior to the onset of domestic violence.

References:

Bavolek, S. J. (1984). *Handbook for the Adult-Adolescent Parenting Inventory (AAPI)*. Park City, UT: Family Development Resources, Inc.

Behar, L. (1977). The Preschool Behavior Questionnaire. *Journal of Abnormal Child Psychology, 5,* 265–275.

Buss, A. H., & Perry, M. (1992). The Aggression Questionnaire. *Journal of Personality and Social Psychology, 63,* 452–459.

Harter, S., & Pike, R. (1984). The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children. *Child Development, 55,* 1969–1982.

Holden, G. W., & Ritchie, K. L. (1991). Linking extreme marital discord, child rearing, and child behavior problems: Evidence from battered women. *Child Development, 62,* 311–317.

Howes, C. (1988). Peer interaction of young children. *Monographs of the Society for Research in Child Development, 53* (Serial No. 217, No. 1).

Kingston, L., & Prior, M. (1995). The development of patterns of stable, transient, and school-age onset aggressive behavior in young children. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 348–358.

McCloskey, L. A., Figueredo, A. J., & Koss, M. P. (1995). The effects of systemic family violence on children's mental health. *Child Development, 66,* 1239–1261.

Piotrkowski, C. S., Collins, R. C., Knitzer, J., & Robinson, R. (1994). Strengthening mental health services in Head Start. *American Psychologist, 49,* 133–139.

Strassberg, Z., Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994). Spanking in the home and children's subsequent aggression toward kindergarten peers. *Development and Psychopathology, 6,* 445–461.

Takanishi, R., & DeLeon, P. (1994). A Head Start for the 21st century. *American Psychologist, 49,* 120–122.

Wentzel, K. R., Feldman, S. S., & Weinberger, D. (1991). Parental child rearing and academic achievement in boys: The mediational role of social-emotional adjustment. *Journal of Early Adolescence, 11,* 321–339.

Foster Parent Hassles Scale: Initial Development and Psychometric Properties

Kristine L. Herman, Gary Creasey, Matthew Hesson-McInnis

PRESENTER: Kristine L. Herman

Foster-parent stress from an ecological systems perspective was analyzed. The Foster Parent Hassles Scale (FPHS) was then developed and compared with existing stress measures. Initial results indicate that the FPHS may be used to identify more effectively those foster parents in need of supportive services.

(Abstract from original proposal; paper summary not received for publication.)

Mental Health

The Influence of Instructional Method, Social Self-Concept, and Affective Perspective Taking on Children's Social-Cognitive Zone of Proximal Development

Erika E. Bolig, Jeanne D. Day

PRESENTER: Erika E. Bolig

Social competence plays an important role in life adjustment. For example, children with low levels of social competence are often victims of social rejection and/or isolation, experience less happiness (Michelson, Sugai, Wood, & Kazdin, 1983) and more loneliness, and have lower self-esteem than do children with moderate to high levels of social competence (Kennedy, 1988). In addition, deficiencies in social skills during childhood are related to later mental health problems (Matson & Ollendick, 1988), school dropout, juvenile and adult crime, and adult psychopathology (Eron & Heusmann, 1984; Parker & Asher, 1987).

Given the significant role of social skills, it is important to provide children with opportunities to acquire and practice prosocial skills in the hope of preventing negative consequences associated with social skills deficits. It is also important to explore influences on social skills development. Consequently, the major goals of this study were: (a) to increase the number of prosocial solutions and consequences generated by children for four interpersonal dilemmas, (b) to examine whether children learn social problem solving more easily under didactic or contextualized instruction or whether there are individual differences in which method of instruction is more beneficial, (c) to test Vygotsky's (1978) theory that children's responsiveness to instruction provides information beyond that provided by static measures of ability, and (d) to examine the influence of social self-concept and affective perspective taking on children's social problem solving pretest, training, and posttest performance. Participants were 104 children attending Head Start. Children received nine assessments: social self-concept, affective perspective taking, social problem solving pretest, two didactic and two contextualized instruction sessions, and a posttest following the training sessions for each method of instruction.

Practically and statistically, significant gains from pretest to posttest were observed in the number of prosocial solutions and consequences generated. On average, children's posttest performance following didactic and contextualized instruction did not significantly differ; however, individual differences in which method of instruction was more beneficial were observed. Posttest performance following didactic instruction was significantly predicted by training performance and pretest performance (marginally significant); posttest performance following contextualized instruction was significantly predicted by training performance. Affective perspective taking significantly predicted pretest performance, training performance during didactic (marginally significant) and contextualized instruction, and posttest performance following didactic and contextualized instruction. Social self-concept marginally significantly predicted training performance during contextualized instruction and significantly predicted posttest performance following didactic instruction.

The findings of this study have important implications for Head Start. The significant improvement in children's prosocial problem solving as a result of the instruction supports the

inclusion of a social problem-solving program in the mental health curriculum. This is particularly important given the influence of social skills on adjustment during childhood and later life as well as social competence being the proposed criterion on which to base the success of Head Start (Zigler, 1973; Zigler & Trickett, 1978). Furthermore, the findings suggest that the social problem-solving instruction should include both didactic and contextualized learning opportunities and that activities which help children develop and practice affective perspective taking should also be included.

References

Eron, L., & Heusmann, R. (1984). The relation of prosocial behavior to the development of aggression and psychopathology. *Aggressive Behavior*, 10, 201–211.

Kennedy, J. H. (1988). Issues in the identification of socially incompetent children. *School Psychology Review, 17*, 276–288.

Matson, J. L., & Ollendick, T. H.(1988). *Enhancing children's social skills: Assessment and training*. New York: Pergamon Press.

Michelson, L., Sugai, D. P., Wood, R. P., & Kazdin, A. E. (1983). Social skills assessment and training with children: An empirically based handbook. New York: Plenum Press.

Parker, J. G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low accepted children at risk? *Psychological Bulletin, 102*, 357–389.

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes* (M. Cole, V. John-Steiner, S. Scribner, & E. Souberman, Eds. & Trans.). Cambridge: Harvard University Press.

Zigler, E. (1973). Project Head Start: Success or failure? *Learning, 1*, 43–47.

Zigler, E., & Trickett, P. K. (1978). IQ, social competence, and evaluation of early childhood intervention programs. *American Psychologist, 33*, 789–798.

Child Behavior and Social Competence Predicts Parent Stress in Children in Head Start

Cynthia Wilcox, Laura Foster, Bruno Anthony, Sheila Dennis, Jennifer Branch, Celene Domitrovich, Dominique Charlot-Swilley, Robinson Munoz-Millan

PRESENTERS: Cynthia Wilcox, Dominique Charlot-Swilley, Bruno Anthony

Social competence, internalizing behaviors, and externalizing behaviors were examined in relation to parent stress for a group of 101 Head Start children and their parents. The results indicate that children who exhibit externalizing behaviors in school are seen by their parents as difficult children. Children who evidence internalizing behaviors and poor social competence in preschool are likely to have parents who report higher levels of stress and who report difficulties in the parent-child relationship.

(Abstract from original proposal; paper summary not available for publication.)

Parents' and Teachers' Assessment of Behavior Strengths and Difficulties in Preschoolers: Why They Agree and Why They Do Not Agree

Lauren Abramson, Belinda Sims, Philip Leaf, Farrah Duffy, Helen Spence, LaVern Stewart

PRESENTERS: Lauren Abramson, Farrah Duffy, Cleona Garfield, Phil Leaf, Helen Spence, LaVern Stewart, Doris Welcher

Research indicates that parents and teachers often rate the same child's behavior differently, but the reasons for these differences are not well understood. Parents and teachers from two Head Start centers rated behavior for 141 children. Parents tended to rate fewer behavior problems than teachers. Factors explored included teachers' experience, age, and parents' social support and depression.

Many observers have noted that the differences in behavior ratings when the same child is rated by their teacher and by their parent. However, there has been less inquiry into the specific factors that contribute to the reasons why different people rate the same child's behavior differently. Further, while some studies have been conducted on the topic for older children, no known studies have examined these issues as they relate to Head Start preschool children. This kind of information can help staff and families understand differences in how a child is perceived by different people. It can also be useful for policy makers who are trying to learn more about the factors that affect the prevalence of behavioral and emotional difficulties in young children.

The purpose of this study was to explore the factors associated with different child behavior ratings of parents and teachers. The factors examined included those for the teacher (age, number of years teaching experience, education level), and the parent (social support, discipline techniques, depression and hostility).

This study consisted of a sample of parents and teachers from two Head Start centers in Baltimore, Maryland. The centers are located in two West Baltimore neighborhoods, both of which have predominantly low-income African American residents. One center is based in an elementary school and one center is based in a church. The teachers at both centers are all female.

The Preschool Behavior Checklist (Behar & Stringfield, 1974) was used to assess behavior difficulties. This is a 30-item checklist with 3-point ratings. The instrument yields a total score as well as subscale scores for aggression, hyperactivity, and anxious behavior. Because this instrument only addresses behavior difficulties, we also included 10 items relating to behavior strengths, so that parents and teachers would also have the opportunity to rate positive behaviors. Analysis of differences between parents and teachers in rating a child's strengths were performed separately from the behavior problems. Data were analyzed for ratings obtained in the late fall, at baseline. The number of children rated by both parent and teacher was 141.

Overall, parents tended to rate their children with fewer behavior difficulties than did teachers. Our data indicate that this finding is related to parental symptoms of depression. For example, parents who reported less depression tended to rate their child as being less aggressive than did the child's teacher. However, parents who reported higher levels of depression were in greater agreement with teachers about the extent of hyperactivity in the child. Interestingly, these depressed parents also tended to rate their child as being less anxious than did the child's teacher. With respect to factors which were associated with teacher ratings of behavior problems, our findings indicated that teachers with Early Childhood certificates or Child Development Associate credentials rated more children as having behavior difficulties than did teachers with Bachelors or Masters degrees. These and other findings in this study suggest that there are many factors which may contribute to the differences and similarities between parents and teachers' ratings of a child's behavior.

Influence of Community Violence on Head Start Children's Language, Motor, and Socioemotional Development

Sally A. Koblinsky, Suzanne M. Randolph, Debra D. Roberts

PRESENTERS: Sally A. Koblinsky, Suzanne M. Randolph, Debra D. Roberts

Community violence is epidemic in the United States and is now targeted as a major public health problem (USDHHS/PHS, 1992). Growing numbers of Head Start families live in urban neighborhoods where they are vulnerable to direct exposure (e.g., robberies) or indirect exposure (e.g., hearing gunshots) to community violence. Community violence can be viewed as an ecological stressor that interacts with individual, family, neighborhood, and cultural factors, and has the potential to jeopardize young children's normative development and mental health.

Although researchers recognize the potential risks associated with living in violent neighborhoods, few empirical studies examine the prevalence or effects of young children's exposure to community violence. Much of the existing literature focuses on elementary-age or adolescent children. Most studies are clinical or anecdotal in nature, and contain a variety of methodological problems (Levitt & Fox, 1993).

To advance theory and knowledge in this field, we sampled 104 urban, African American Head Start families to investigate the relationship between levels of community violence exposure and children's language, motor, and socioemotional development. The sample included preschool children, their mothers, and their Head Start teachers from the Washington, DC, metropolitan area. Data from police and Head Start representatives were used to target high- and low-violence neighborhoods. Trained interviewers administered a demographic questionnaire, the Social Skills Rating Scale, and the Child Behavior Checklist to mothers of the Head Start children. The Denver II was administered to preschoolers.

With respect to the Head Start children's developmental status, 58% of the preschoolers in high-violence neighborhoods and 50% of those in low-violence neighborhoods exhibited at least one delay in one or more developmental areas on the Denver II. Approximately 15% of the children in high-violence neighborhoods and 12% in low-violence neighborhoods displayed at least two delays in major developmental areas. These findings were especially compelling given that the developmental measure was administered at the end of the Head Start year. The small difference in the developmental status of children in high- and low-violence neighborhoods may be attributed to the fact that we found relatively high levels of gunshots and other signs of violence in many of the neighborhoods that had been designated "low-violence."

Findings further revealed that substantial numbers of children in our sample engaged in externalizing and internalizing behaviors. Externalizing problems included aggressive behavior such as kicking, hitting, temper tantrums, and attacking other children and teachers when angry. Internalizing problems included severe anxiety, withdrawal, fearfulness, and extreme dependency on adults. Approximately 39% of girls and 29% of boys in high-violence neighborhoods exhibited externalizing behaviors at least one standard deviation above the mean for nonclinical samples. In addition, 12% of girls and 21% of boys in these neighborhoods displayed internalizing behaviors at least one standard deviation above the nonclinical mean. The high level of externalizing behaviors among preschool girls in violent neighborhoods was of particular interest given girls' more common pattern of exhibiting internalizing behaviors under stress. Both the mental health and developmental findings of this study will be used to develop culturally specific intervention strategies for educators, parents, and policy makers that promote positive outcomes for preschoolers exposed to community violence.

References

Leavitt, L. A., & Fox, N. S. (1993). *The psychological effects of war and violence on children*. Hillsdale, New Jersey: Erlbaum.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and posttraumatic stress in school-age children. *Archives of General Psychiatry, 44*(12), 1057–1063.

Garbarino, J., Dubrow, N., Kostelny, M. K., & Pardo, C. (1992). *Children in danger: Coping with the consequences of community violence.* San Francisco: Jossey Bass.

Osofsky, J. D., Wewers, S., Hann, D. M., & Fick, A. C. (1993). Chronic community violence: What is happening to our children? *Psychiatry, 56,* 36–45.

US Department of Health and Human Services/Public Health Services. (1992). *Healthy people 2000: National health promotion and disease prevention objectives.* Boston: Jones & Barlett.

Changes in Homeless and Housed Children's Social-Emotional Development During the Head Start Year

Amy Gordon, Sally A. Koblinsky, Elaine Anderson

PRESENTERS: Amy Gordon, Sally A. Koblinsky, Elaine Anderson

An increasing number of children in the U.S. are homeless (US Conference of Mayors, 1995). Research indicates that homelessness may have particularly adverse effects on preschoolers who have been found to manifest significantly higher levels of social maladjustment and behavior problems than their housed counterparts (Rescorla, Parker, & Stolley, 1991; Wood, Valdez, Hayashi, & Shen, 1990). Comprehensive early childhood education programs, such as Head Start, may help reduce the negative effects of homelessness on preschoolers' development. However, there is currently little research examining the impact of Head Start on homeless children's social-emotional development.

This study examined changes during the Head Start year in the social skills and behavior problems of 38 homeless and 46 housed African American preschoolers. A pre and posttest design was used, and data were collected through parent and teacher interviews over a 6-month period of the Head Start year. The measures used to examine children's social-emotional development were: (a) the Adaptive Social Behavior Inventory that assesses young children's compliant, expressive, prosocial, and disruptive social skills (ASBI; Hogan, Scott, & Bauer, 1992) and (b) the Behavior Problems Index that rates children's antisocial, headstrong, hyperactive, anxious/depressed mood, immaturity, and peer conflict/social withdrawal behavior problems (BPI; Zill, 1990).

Analyses of covariance were used to determine if there were significant differences in the change scores (i.e., difference between the pre and posttest scores) of the 10 dependent measures as a function of the child's housing status and gender while controlling for the pretest scores. The results reveal significant differences in the change scores of homeless and housed children's social skills and behavior problems.

In the area of social skills, mothers' responses indicate that homeless children experienced a significantly greater decrease in compliant behavior than housed children who increased in compliance during the year. Teacher ratings also indicate that homeless children experienced a significantly greater decline in expressiveness than housed children. Results of teachers' responses reveal that boys experienced significantly greater decreases in compliant and expressive behavior during the year than girls.

As for changes in behavior problems, results reveal many significant differences between the homeless and housed preschoolers. According to mothers' reports, homeless children experienced a significantly greater increase in anxiety/depression, headstrong behavior, hyperactivity, peer conflict/social withdrawal, and total behavior problems as compared to the housed

children who declined in these areas during the year. Results of mothers' ratings also reveal that homeless and housed girls experienced a significantly greater increase than boys in these same behavior problems. Teacher ratings reveal that homeless preschoolers experienced significantly greater increases than housed preschoolers in all behavior problems, except hyperactivity. There were no significant differences in the change scores of boys and girls on any of the measures completed by teachers.

Although the children in this study were enrolled in a comprehensive early childhood program, results suggest that the stressors of homelessness outweighed the many potential benefits of Head Start. These findings reveal an urgent need for Head Start interventions to focus directly on the negative social outcomes associated with young children's experience of homelessness.

References

Hogan, A. E., Scott, K. G., & Bauer, C. R. (1992). The Adaptive Social Behavior Inventory (ASBI): A new assessment of social competence in high risk 3-year-olds. *Journal of Psychoeducational Assessment, 10*(4).

Rescorla, L., Parker, R., & Stolley, P. (1991). Ability, achievement, and adjustment in homeless children. *American Journal of Orthopsychiatry, 61*(2), 210–220.

US Conference of Mayors. (1995). *A status report on hunger and homelessness in America's cities: 1995.* Washington, D.C.: US Conference of Mayors.

Wood, D. L., Valdez, R. B., Hayashi, T., & Shen, A. (1990). Health of homeless children and housed, poor children. *Pediatrics, 86*(6), 858–866.

Zill, N. (1990). *Behavior Problems Index based on parent report.* Unpublished Measure. Washington, DC: Child Trends.

Cognitive Moderators of Parental Violence Exposure and Trauma Response

Jennifer C. West, Nina Frasier, Joyce Ho, B. B. Robbie Rossman

PRESENTER: Nina Frasier

Research on young children's exposure to violence and possible posttraumatic reactions has critical pragmatic implications. Researchers have emphasized both the prevalence of violence exposure and the resultant Posttraumatic Stress Disorder (PTSD) symptomatology for young children (Fantuzzo, Boruch, Beriana, Atkins, & Marcus, 1997; Rossman & Ho, 1998). Exposure to parental violence and PTSD reactions may interfere with cognitive processing (Crick & Dodge, 1994; Rossman & Ho, in press); exposed children may be at a disadvantage in educational settings if their informational intake capabilities have been compromised.

We examined the usefulness of two informational intake measures expected to be protective moderators of the negative effects of exposure and PTSD symptoms on young children's school and behavioral functioning. Eighty-two children ranging in age from 5 to 7 and their mothers from four exposure groups participated. Sixty percent were from minority families; all were of middle to lower SES. Mothers completed measures of demographic information, children's school performance, spousal verbal and physical aggression (Conflict Tactics Scales; Straus, 1979), and behavior problems (Child Behavior Checklist; Achenbach & Edelbrock, 1983). Children completed measures assessing PTSD symptoms (PTSD Reaction Index; Pynoos, 1987) and receptive language ability (Peabody Picture Vocabulary Test; Robertson & Eisenberg, 1981). Sharpening (quick and accurate detection of change) of nonaggressive cues (Leveling/Sharpen-

ing Shootout Test; Santostefano & Rieder, 1984) was used to index processing of neutral information such as that typically received in educational settings.

After controlling for SES, we found that witness children were experiencing greater parental verbal and physical aggression, PTSD symptoms, and behavioral difficulties than nonwitness children. Nonabused shelter witness children, who were exposed to the highest level of marital violence, had the lowest verbal IQ scores. Moderator hierarchical multiple regressions were used to predict either behavior problems or school performance, with stressor scores (total spousal aggression or PTSD symptoms), PPVT-IQ or LSSOT-NA moderator scores, and scores for the interaction of the stressor with the moderator used as predictors. For school performance and behavior problems, both PPVT-IQ and LSSOT-NA acted as significant moderators. Higher moderator scores appeared to benefit children at lower stressor levels but put those at higher stressor levels at a disadvantage with regard to good school performance or fewer behavior problems.

This pattern of results has several implications. First, verbal comprehension is not necessarily compromised for all exposed youngsters since only the highest violence exposure group showed poorer performance. However, assessment of information intake capabilities of young child witnesses is important, particularly for those exposed to severe violence. Moderator regression analyses suggested that informational intake capabilities are advantageous in less adverse circumstances, but may handicap a child experiencing greater adversity from exposure or trauma reactions. These results address the point made by Masten and Wright (1998) who encourage researchers to examine the role of moderator variables for high-risk children rather than assuming that it will be the same as that of lower-risk children. The cost of retaining good informational intake capabilities may be an overawareness of violence, resulting in greater distress that increases behavioral problems and interferes with the ability to learn in school. Remediation of these capabilities, however, needs to be done carefully if the child remains exposed, since it may rob the child of protection he or she needs in a violent home.

References

Achenbach, T. M., & Edelbrock, C. S. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile.* Burlington: University of Vermont.

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information-processing mechanisms in children's social adjustment. *Psychological Bulletin, 115,* 74–101.

Fantuzzo, J., Boruch, R., Beriana, A., Atkins, M., & Marcus, S. (1997). Domestic violence & children: Prevalence and risk. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 116–122.

Masten, A. S., & O'Dougherty Wright, M. (in press, 1998). Cumulative risk and protection models of child maltreatment. In B. B. R. Rossman & M. S. Rosenberg (Eds.), *Multiple victimization of children: Conceptual, developmental, research, and treatment issues.* Binghamton, NY: Haworth Press.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and posttraumatic stress in school-age children. *Archives of General Psychiatry, 44,* 1057–1063.

Robertson, G., & Eisenberg, J. (1981). *Peabody Picture Vocabulary Test-Revised technical supplement.* Circle Pines, MN: American Guidance Service.

Rossman, B. B. R., & Ho, J. (in press, 1998). Posttraumatic response and children exposed to parental violence. In R. Geffner and P. Jaffe (Eds.), *Children exposed to family violence: Intervention, prevention, and policy implications.* Binghamton, NY: Haworth Press.

Santostefano, S., & Rieder, C. (1984). Cognitive controls and aggression in children: The concept of cognitive-affective balance. *Journal of Consulting and Clinical Psychology, 52,* 46–56.

Straus, M.A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. *Journal of Marriage and the Family, February,* 75–88.

Relationship of Children's Behavior Problems to Mothers' Responses to Noncompliance, Misbehavior, and Distress

Laura Hubbs-Tait, Anne McDonald Culp, Rex E. Culp,
Molly Anne Miller Steele, Carolyn Vass Fore

PRESENTERS: Laura Hubbs-Tait, Anne McDonald Culp, Rex E. Culp, Charles Hare

Parenting styles have long been thought to be related to children's behavior problems. Permissive parenting is associated with impulsivity and aggression. Authoritarian parenting is associated with social withdrawal. In contrast, authoritative parenting is associated with social competence (Baumrind, 1967, 1971; Maccoby & Martin, 1983). More recent research with Maccoby and Martin's fourfold typology suggests that permissive parenting, whether it is indulgent or neglectful, is associated with externalizing behavior problems (Lamborn, Mounts, Steinberg, & Dornbusch, 1991).

Examining the components of the fourfold typology does not yield the same picture of the impact of parenting on children's behavior problems as do the four styles themselves. In particular, power assertion, the type of discipline associated with authoritarian parenting, is related to both aggression and social withdrawal, whereas authoritarian parenting is related only to withdrawal (Lamborn et al., 1991). These contradictory results may be due to the fact that the fourfold typology blurs an important distinction. The meaning of a response to distress may differ from the meaning of the same response to misbehavior or noncompliance. For example, permissively bribing a child not to hit may reward the child's hitting or offering a similar bribe to a child to stop being distressed ignores the child's emotional needs.

The purpose of the study was to examine maternal responses to children's misbehavior, noncompliance, and distress. Key research questions included: (a) Is a power-assertive response to misbehavior or noncompliance associated with children's externalizing problems, internalizing problems, or both? (b) When power assertive responses to children's misbehavior or noncompliance and warm responses to children's distress are compared, which response has the most impact on children's behavior problems? and (c) Are permissive responses to misbehavior, noncompliance, and distress associated with the same or different behavior problems?

Participants were 167 primary caregivers (162 mothers, 2 stepmothers, and 3 grandmothers) and their 4-year-old children (78 boys, 89 girls) who attended one of eight rural Head Start programs in 1995-1996 or 1996-1997. Primary caregivers ranged in age from 19 to 54 years (M = 29.4). Twenty percent did not have a high school diploma, 36% were high school graduates, 11% were vocational-technical graduates, 28% had some college, and 5% were college graduates. Thirteen percent received public assistance (AFDC or TANF), 68% received other forms of public assistance (e.g., food stamps, WIC), and 18% received no assistance. Children's ethnicity was 56% Caucasian, 29% Native American, 7% African American, 5% Latino, and 3% multiethnic.

In the spring of the year their child was enrolled in Head Start, primary caregivers completed the Computer Presented Parenting Dilemmas (CPPD), an interactive computer assessment modified from Holden's Computer Presented Social Situations (Holden & Ritchie, 1991). Included as named family members in the vignettes are the Head Start child, the mother (or primary caregiver), and other family members, as relevant. Included as an unnamed participant in three vignettes is "your child's friend." Three dilemmas assess parental reactions to child noncompliance, three assess reactions to child distress, and three assess parental reactions to a child's play with peers.

Approximately 3 weeks after the primary caregiver completed the CPPD, her child's Head Start teacher completed the Preschool Behavior Questionnaire (PBQ; Behar, 1977) and Howes' Rating Scale for Social Competence with Peers (1988). PBQ subscales, alphas, and means for the current sample are as follows: Hostile/Aggressive (.94; M = 4.58), Hyperactive/Distractible

(.88; M = 1.90), and Anxious/Withdrawn (.74; M = 2.43). Howes' scale includes two behavior problems subscales: Hesitant (alpha = .78) and Difficult (alpha = .89). The three subscales about externalizing behavior—Hostile/Aggressive, Hyperactive/Distractible, and Difficult—were highly correlated (all $rs > .65$). Thus, these three measures were combined to yield an Externalizing scale (alpha = .96).

The study examined the relationship of parental power assertion to externalizing problems, anxiety, and hesitancy. The power assertion factors identified by the CPPD were correlated with Head Start teachers' ratings of externalizing problems. Furthermore, a mother's power assertion directed specifically to her child's aggression against another child explained significant incremental variance in externalizing problems. In contrast to the significant relationship between power assertion and externalizing problems, the relationship between power assertion and the internalizing problems of anxiety and hesitancy was minimal.

Power assertive responses to children's misbehavior or noncompliance and warm responses to children's distress were compared. In line with other recent research (e.g., Pettit, Bates, & Dodge, 1997), the current study indicates that supportive parenting explains significant variance in children's externalizing problems after the relationship between power assertive parenting and externalizing problems has been accounted for. In the current study, as parental warmth in response to children's distress increases, the externalizing scores of these Head Start children decrease even after the impact of power assertion on externalizing problems has been explained.

Parental power assertion specifically in response to children's hitting did explain significant variance in children's behavior problems, even after parental warmth had been entered into the regression equation. This finding underscores the importance of examining not only general parental disciplinary styles (e.g., power assertion) but also parental responses specifically directed to child aggression.

Permissive responses to misbehavior, noncompliance, and distress and behavior problems were assessed for association. The current study identified a variety of permissive parenting factors. Responding to children with offers of treats constituted a factor in the analyses of both the distress and noncompliance stories. The analysis of the noncompliance stories yielded an Ignore factor that included one item that appeared to be interpreted as punitive by mothers. The analysis of the distress stories even more clearly resulted in an Ignore factor that coupled ignoring the child's distress with punitive responses to that distress. The analysis of the three peer monitoring dilemmas yielded a Permissive factor that coupled ignoring the child's behavior with bribing the child and responding to hitting by not pointing out the consequences for the other child (i.e., the opposite of induction).

Three of these five permissive factors were related to children's behavior problems. Offering children a treat to stop crying was related to their hesitant scores. Ignoring children's noncompliance and permissively responding to their hitting were related to their anxious scores. None of the parental permissive factors was related to teachers' ratings of children's externalizing problems. Thus, during their prekindergarten Head Start year, these children's behavior problems appear to be differentially related to parental permissive responses as a function of whether those permissive responses were to distress versus overall noncompliance and the specific misbehavior of hitting another child.

References

Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs, 75*, 43–88.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monographs, 4*(1, Pt. 2).

Behar, L. (1977). The Preschool Behavior Questionnaire. *Journal of Abnormal Child Psychology, 5*, 265–275.

Holden, G. W., & Ritchie, K. L. (1991). Linking extreme marital discord, child rearing, and child

behavior problems: Evidence from battered women. *Child Development, 62,* 311–317.
Howes, C. (1988). Peer interaction of young children. *Monographs of the Society for Research in Child Development, 53*(Serial No. 217, No. 1).
Lamborn, S., Mounts, N., Steinberg, L., & Dornbusch, S. (1991). Patterns of competence and adjustment among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Development, 62,* 1049–1065.
Maccoby, E., & Martin, J. (1983). Socialization in the context of the family: Parent-child interaction. In E. M. Hetherington (Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (pp. 1–102). New York: Wiley.
Pettit, G. S., Bates, J. E., & Dodge, K. A. (1997). Supportive parenting, ecological context, and children's adjustment: A seven-year longitudinal study. *Child Development, 68,* 908–923.

Integrative Research and Intervention to Facilitate Child and Family Development, Education, Readiness for Head Start, and Family Self-Sufficiency

Leah Blumberg Lapidus

PRESENTERS: Eric Finn, Miles Hutton, Leah Blumberg Lapidus, Sonia Reese

Mastery-furthering Community Impact programs and 6-week focused group interventions for children and families are predicted to increase children's emotional security and readiness for healthy learning while enhancing family interactions among Head Start-aged preschoolers, their parents, and caretakers, including grandparents and older siblings. Two initiatives are evaluated: (a) the effectiveness of existing community programs for families within and outside of Head Start and (b) an innovative competence-building, focused program for culturally diverse groups coping with either routine developmental stressors of parent/child interaction or extreme stress and trauma. These initiatives also implement theory-based research and techniques to facilitate optimal mental health in children and families, which may contribute to policy initiatives within Head Start.

Empirically measured outcome evaluation for participants in the comprehensive Community Impact programs serving New York is currently being conducted. Community Impact provides such children's services as tutoring, mentoring, Early Head Start and related enrichment activities, preschool-enhanced child care, adolescent and adult literacy programs, ESL, drug rehabilitation, AIDS support, and food kitchens (Reese, 1997). Specific, hypothesized, beneficial effects upon parents and children of Community Impact's Food Pantry, Peace Games (conflict resolution skills training), and GED training programs, along with the duration and generalizability of the gains are being tested. Preliminary data suggest lasting benefits from these interventions. The second focus of this project is the introduction of specific mastery-furthering programs to enhance the gains of the Head Start or community services children and families are accessing and to reach the isolated families struggling with domestic violence and HIV/AIDS in mothers and children.

The theoretical/empirical base of this project's interventions is derived from more than 40 years of international research on psychological differentiation. Differentiation is a major formal property of an organismic system characterized by greater heterogeneity and segregation of functions and by specialization within functions, which tends to increase developmentally from infancy to maturity (Witkin, Dyk, Faterson, Goodenough, & Karp, 1962). Differentiation is operationally defined as relatively stable patterns of performance on neutral perceptual tasks, including geometric figure-ground discrimination in field independence/dependence, such as

the Group Embedded Figures Test, and cognitive flexibility/constriction, such as the Color Word Test (Lapidus,1969, 1986). Differentiation discriminates patterns of parent-child interaction in many countries (Lapidus,1991), can be rapidly taught (Mshelia & Lapidus,1990), predicts psychophysiological arousal and efficiency in learning to cope with stress in children (Mead & Lapidus,1989), discriminates realistic/unrealistic self-appraisal in alcoholics and nonalcoholics (McIntyre &Lapidus,1989), and consistently identifies general personality characteristics and patterns of adaptive mastery in coping with both unusual stress and normal life tasks (e.g., pregnancy, childbirth, parenting, information seeking, and participation in training programs).

The specifically focused 6-week differentiation furthering group interventions are predicted to improve: (a) pretested coping skills, (b) competencies, (c) family interactions, (d) education readiness in pre- and Head Start-aged children, (e) actual achievement in older siblings, parents, and caretakers, and (f) self-sufficiency in all participants. Initial project results support these hypotheses. The differentiation-furthering program involves training in normative development and goal setting, spatial relations, emotional intelligence, (Citkowitz & Lapidus, 1980), cognitive enrichment, (Schmolling & Lapidus, 1977), guided discussion of tasks' application, and postintervention measures of success.

References

Citkowitz, R., & Lapidus, L. B. (1980). Effects of paraphrasing, modeling, and cues in facilitating self-reference affective statements by chronic schizophrenics. *Psychological Reports, 47,* 523-536.

Lapidus, L. B. (1969). Cognitive control and reactions to stress: Conditions for mastery in the anticipatory phase. *Proceedings of the 77th annual convention of the American Psychological Association, 4,* 569–570.

Lapidus, L. B. (1986). Hormones, perceptual efficiency, and sexuality. *Journal of Psychosomatic Obstetrics and Gynecology, 6*(4), 491–500.

Lapidus, L. B. (1991). Cross-cultural consistencies in prenatal perceptual patterns and perinatal practices. *International Journal of Prenatal and Perinatal Studies, 3*(3/4), 155–167.

McIntyre, B., & Lapidus, L. B. (1989). The relationship between psychological differentiation and performance expectation in alcoholics and normals. *Journal of Clinical Psychology, 45,* 454- 461.

Mead, R., & Lapidus, L. B. (1989). Psychological differentiation, arousal, and lipreading efficiency in hearing-impaired and normal children. *Journal of Clinical Psychology, 45,* 851–859.

Mshelia, A. Y., & Lapidus, L. B. (1990). Depth picture perception in relation to cognitive style and training in non-Western children. *Journal of Cross-Cultural Psychology, 21*(4), 414–433.

Reese, S. (1997). *Community impact.* Unpublished manuscript. Columbia University, New York.

Schmolling, P., & Lapidus, L. B. (1977). The effect of enriched conditions on verbal abstracting ability in acute schizophrenics. *Psychological Reports, 41,* 1203–1210.

Witkin, H., Dyk, R. B., Faterson, H. F., Goodenough, D. R., & Karp, S. A. (1962). *Psychological differentiation.* New York: Wiley.

Social Competence and Behavior Problems in Head Start Children: A Longitudinal Study

Laura Foster, Tanya Morrel, Celene Domitrovich, Pamela Flores-Fahs, Jennifer Branch, Sheila Dennis, Robinson Munoz-Millan, Bruno Anthony

PRESENTERS: Laura Foster, Bruno Anthony, Tanya Morrel

Social competence, internalizing behaviors, and externalizing behaviors were examined in 123 Head Start 3- and 4-year-olds using teacher reports on the Social Competence and Behavior Evaluation questionnaire (SCBE; La Freniere & Dumas, 1995). The teachers in two Baltimore area Head Start centers were asked to complete the questionnaires twice, with 6 months between administrations. The sample of children in both administrations was largely African American and was composed of 67 boys and 56 girls.

In order to obtain prevalence estimates of the children's competencies and problems, T-scores on the SCBE summary scales were obtained. The SCBE has four summary scales: Social Competence, Internalizing Problems, Externalizing Problems, and General Adaptation. T-scores of 37 and less indicate significant problems, T-scores of 63 and above indicate significant success, and T-scores between 37 and 63 indicate average adaptation. A striking finding was the high number of mental health problems in this young population: 47% of children had at least one mental health problem, 33% had at least two problems, 21% had at least three problems, and 15% had four or more problems.

In order to determine the relationships between the SCBE summary scales, a Pearson correlation matrix was obtained. As expected, Internalizing and Externalizing scores were significantly correlated. Interestingly, Social Competence scores were significantly correlated with Internalizing scores but not consistently with Externalizing scores.

In order to determine how the children's behavior changes over time while they participate in the Head Start programs, a series of longitudinal analyses were performed. First, Paired Sample t tests were performed using the children's T-scores at Time 1 and Time 2 to establish whether the children's scores changed significantly over time. The Internalizing (t=1.05, df=122, p=.30) and Externalizing (t=.66, df=122, p=.51) scores did not change significantly over time. Social Competence scores improved significantly (t=3.15, df=122, p<.01) as did the General Adaptation scores (t=4.10, df=122, p<.01). Children became less angry, depressed, and isolated and more socially competent and generally adaptive over time. In order to determine if boys or girls changed more over time, change scores were computed and ANOVAs were performed. The only main effect for gender was for the General Adaptation score (F=4.39, p<.05), with only girls changing significantly over time. Chi-square analyses were performed to determine whether more children moved into a more successful range than into a less successful range over time. In general, more children improved than worsened.

These results indicate that: (a) There is a substantial portion of children in Head Start with mental health needs; (b) Internalizing problems is more consistently associated with difficulties of social competence than externalizing problems; and (c) The children in Head Start become more adaptive during a year in the program. More specifically, they become more socially competent, tolerant, joyful, and socially integrated over time.

Reference

La Freniere, P. J., & Dumas, J. E. (1995). *Social Competence and Behavior Evaluation, preschool edition (SCBE)*. Los Angeles: Western Psychological Services.

Effects of Community Violence on Young Children: Examples From the Los Angeles Inner City

Jo Ann M. Farver, Lucia Natera

PRESENTERS: Mercedes Garcia, Donna Iwagaki, Beatrice Price, Karen Veieweg

Despite the rise in neighborhood crime in U.S. cities, there has been more research conducted on the effects of televised violence on young children than on the effects of "real" violence. At present, we know little about the life experiences of very young children who are exposed to chronic violence. Accordingly, this study investigated the extent to which children and their families are exposed to neighborhood violence and explored the cognitive, social, and emotional consequences of this exposure for young children.

Forty-four preschoolers (Mean age = 48.22 months; 50% girls) and their mothers participated in the study. Mothers were interviewed about their family demography, violence exposure, intrafamilial conflict, and their children's distress symptoms. Children were interviewed about their violence exposure and observed during free play with peers. Their cognitive, social, and emotional functioning also was assessed. Teachers rated children's behavioral style and social competence.

Results showed that children were exposed to considerable neighborhood violence. Frequencies of children's violence exposure were associated with lower scores on cognitive tests and diminished socioemotional functioning. There were also significant correlations among maternal and child reports of violence exposure, which demonstrated that children as young as age 4 can provide reliable and useful information about their experiences with neighborhood violence. The findings suggest that preschoolers are not immune to violence exposure, but rather are quite aware of violent events taking place in their neighborhoods and seem to be psychologically affected by their experiences. The improved understanding of the nature and consequences of children's exposure to violence can inform practitioners and policy makers in their efforts to address these problems for children and families.

Lessons From the Field: Head Start Mental Health Strategies to Meet Changing Needs

Hirokazu Yoshikawa, Jane Knitzer

PRESENTER: Hirokazu Yoshikawa

This presentation highlights promising strategies from a national study of 73 Head Start partnerships focused on mental health and family support. The results, including recommendations for Head Start at the local, state, and national levels, have appeared in Yoshikawa and Knitzer (1997).

Mental health needs of Head Start families are great, with levels of community, family, and work-related stress on the increase. However, new developments in children's mental health (Knitzer, in press), Head Start quality improvement, and prevention research (Olds, 1998; Yoshikawa, 1995) represent new opportunities for mental health in Head Start.

Head Start programs and partnerships were solicited through mailings, announcements, self-nominations, and contacts. Seventy-three partnerships were identified. Staff at each were contacted by phone or through site visits, and information was gathered on demographic and geographic context, nature of mental health strategies, and comprehensive history of how they

were developed. Fourteen programs and partnerships were chosen for more in-depth qualitative interviews with key informants.

Models of mental health appropriate to Head Start emphasize: (a) sensitivity to meanings of mental health in families and staff of diverse backgrounds, (b) within-classroom strategies rather than pull-out therapy, (c) family-focused rather than child-focused treatment, (d) collaboration with staff rather than independent clinical work, (e) helping staff improve their skills and increasing staff support rather than focusing solely on families, and (f) emphasizing strengths of families and staff rather than solely treating pathology.

Some Head Start programs have made the transition from offsite to onsite models of mental health services. Mental health consultants in such programs are involved in multiple areas, including cofacilitation of parent groups with staff, cofacilitation of staff support groups, weekly case management meetings, and hands-on classroom consultation.

Models exist for how to involve hard-to-engage families in Head Start services. Examples include: (a) use of mentor parents to draw in families; (b) providing services such as support groups, which are nonthreatening yet clinically and culturally sensitive; and (c) providing support groups for staff working with hard-to-engage families.

Strategies sensitive to community and cultural meanings of mental health are essential. Nonthreatening strategies include using first names, avoiding "labeling" phrases, and explicit encouragement of cultural heritage and identity exploration in mental health-related activities.

Few community-wide mental health strategies exist in Head Start. We found the following: (a) Head Start sparking community coalitions to integrate services through co-location or to prevent problem outcomes such as substance abuse and (b) Head Start involvement in system-of-care initiatives.

Directions for future research include: (a) evaluation of community-wide and staff-focused strategies to improve mental health in Head Start; (b) work in developing measures of mental health appropriate for the diverse backgrounds of Head Start families; (c) inclusion of program-level variables in evaluating mental health services in Head Start: increases in staff skills and well-being and changes in contacts between consultants and staff; (d) evaluations across the full diversity of programs, including tribal and migrant programs; (e) evaluations that compare multiple processes of effects; and (f) evaluation of innovative partnerships at state or community levels, including those between Head Start and Temporary Assistance to Needy Families (TANF) programs, managed care, and Medicaid.

References

Knitzer, J. (In press). Early childhood mental health from a systems level perspective. In J. Shonkoff and S. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed.). New York: Cambridge University Press.

Olds, D. (1998, July). *Home-visiting services: Are we going to use evidence to guide policy and practice?* Paper presented at Head Start's Fourth National Research Conference, Washington, DC.

Yoshikawa, H. (1995). Long-term effects of early childhood programs on social outcomes and delinquency. *The Future of Children, 5*(3), 51–75.

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs.* New York: National Center for Children in Poverty and American Orthopsychiatric Association.

Mental Health Consultation in Head Start: The Impact on Teachers' Effectiveness

Paul J. Donahue

PRESENTER: Paul J. Donahue

Clinicians from the Center for Preventive Psychiatry have been consulting to private nursery schools, child care centers, and Head Start programs for the past 30 years. Currently, the Early Childhood Consultation Service at the Center serves eight early childhood programs in the county and is slated to expand from 5 to 16 Head Start centers in September, 1998. The consultants work with staff, children, and parents and spend from a few hours to 2 days a week onsite.

The largest portion of the consultant's time is generally spent working with teachers, either individually or in small or large groups. The consultants' offer didactic workshops for staff, but also take the opportunity to model for teachers and provide more immediate problem solving in the classroom. Consultation to teachers encompasses a range of activities, which can be summarized in four key components:

1. Assessing individual children with identified emotional or behavioral problems and partnering with teachers regarding management issues and behavioral interventions in the classroom.
2. Consulting with staff on the classroom environment, including the developmental appropriateness of play materials and activities, the structure of the room and organization of the day, the opportunity for "feelings" discussions and other emotional interactions with the children, and the effectiveness of disciplinary techniques.
3. Enhancing teacher professionalism in the workplace through increased communication between staff, more rigorous standards of confidentiality and staff/family boundaries, and an open dialogue with administration regarding teacher concerns.
4. Discussing personal problems with staff and their impact on the classroom functioning and helping with problem solving and stress management.

The current pilot study was designed to measure the impact of mental health consultation on teachers' perceived effectiveness and their readiness for consultation, adapting the methods of a recent study of elementary school teachers (Goldman, Botkin, Tokunaga, & Kuklinski, 1997). The study included two main hypotheses: (a) mental health consultation will be positively associated with teachers' sense of efficacy and (b) mental health consultation will be positively related with teachers' readiness to utilize consultation. Two primary instruments were used: the Consultation Readiness Scale (Cherniss, 1978) and the Consultation Outcome Scale (Wright & Fine, 1979).

The study included 32 teachers at a combined Head Start/child care center that primarily serves an African American population in an urban setting. Teacher contacts with the consultant were charted over 7 months of an academic year. Sixteen of the teachers sought out the consultant for individual sessions (M=3.8). The other 16 only participated in group discussions (M=1.5).

The first hypothesis was not supported by the data, as consultation use was not significantly correlated with teachers' sense of their own efficacy as measured by the Consultation Outcome Scale. In reviewing the data, it was evident that teachers with greater usage tended to discriminate more on the self-efficacy items than their lower-use peers, who tended to uniformly rate their experience with the consultant and their own abilities in the high average range. Further studies should include more teacher training on completing this self-rating scale.

The second hypothesis was supported by the data, as consultation use was significantly correlated (p<.05) with the program director's end of the year rating of the teachers' willingness and ability to use consultation. The initial ratings prior to the consultation were positive but not

significant. Those teachers who sought out individual consultation time were also rated significantly higher on the Consultation Readiness Scale ($p<.05$) than their peers who only met with the consultant in groups. These findings suggest that certain teachers are more predisposed to work with a mental health consultant and that their interest in trying new techniques and in partnering in the classroom will increase after their consultation experience. The director's rating of the teachers' consultation readiness at the end of the year was also significantly correlated with their sense of efficacy on the Consultation Outcome Scale ($p<.05$).

References

Cherniss, C. (1978). The consultation readiness scale: An attempt to improve consultation practice. *American Journal of Community Psychology, 6*, 15–21.

Goldman, R. K., Botkin, M. J., Tokunaga, H., & Kuklinski, M. (1997). Teacher consultation: Impact on teachers' effectiveness and students' cognitive competence and achievement. *American Journal of Orthopsychiatry, 67*(3), 374–384.

Wright, J., & Fine, M. (1979). *Consultation effectiveness scale: Field test instrument.* Unpublished manuscript, University of Kansas, Lawrence.

Perceived Social Support Among Head Start Families: Implications for Promoting Factors Which Enhance Resilience

Andrea Sobel

PRESENTERS: Thelma Lorraine Harley, Andrea Sobel

This study draws from the seminal research of Anthony (1987), Garmezy (1995), and Werner (1990), who suggested that the focus of intervention programs for young children should be based on an increased understanding of "what is right" with children rather than "what is wrong". From this work, and from that of Grotberg (1995), the following definition of resilience emerged: Resilience is seen as a dynamic, changing capacity, which allows an individual to prevent, minimize, or overcome the damaging effects of adversity.

Guided by this belief about resilience, this study investigated the importance of social support as a protective factor for families living in poverty. Social support has been identified in resilience studies (Werner, 1990; Anthony, 1987) as being present in the lives of resilient adults. A relationship between family social support and resilient qualities in young children has been described in terms of its impact on parenting behavior (Dunst, Trivette & Deal, 1988; Roggman, Moe, Hart & Forthun, 1994). The central theme of this study is the synergistic relationship between parent(s) and child(ren) as they respond to stress and support in their lives, and how this relationship affects the potential resilience of the child.

Primary caregivers from two communities representing different ethnic make-ups were interviewed about parenting stress and social support. Both groups revealed an extremely high level of stress in their lives. The intensity of that stress, and its impact on the child's well-being, was illustrated by the following comment: "It's that the rent is due, that there is no money for the rent, that there's no dinner...It's already six o'clock and we have to eat...So it's like that, when moments of crisis come, I try to cry. I ignore them completely...I try to do what I need to do. But sometimes I explode, I explode and I scold them all..."

The development of resilience in young children may be hampered by this extreme level of stress. Through an analysis of the parents' perceptions of their social support, a better understanding of that support as a mediator to stress emerged. Parents found that their total support

ranged between sometimes helpful to generally helpful. They described the impact of Head Start as being one of their most helpful sources of support. The two communities varied significantly in the make-up of their social support networks.

The context of play was utilized to identify factors contributing to a child's resilience. Head Start teachers were interviewed to discuss the play of each of their children participating in the study. A resilience framework guided these interviews. Anecdotal observations provided additional information about the child's play behaviors.

An understanding of the complex relationship among parenting stress, the nature and helpfulness of parents' social support, and the child's resilient capabilities is crucial if Head Start is to enhance its impact on the development of resilience in young children. Each community brings its own stresses and strengths to the formula of making a difference in a child's life. Identifying and promoting the strengths of children and their families is at the heart of a resilience paradigm.

References

Anthony, E. J. (1987). Risk, vulnerability, and resilience: an overview. In E. J. Anthony & B. J. Cohler (Eds.), *The invulnerable child,* (pp 3–48). New York: The Guilford Press.

Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families.* Cambridge, MA: Brookline Books.

Garmezy, N. (1985). Stress-resistant children: The search for protective factors. In J. E. Stevenson (Ed.), *Recent research in developmental psychopathology,* (pp. 213–233). Oxford: Pergamon Press.

Grotberg, E. (1995). *A guide to promoting resilience in children: Strengthening the human spirit.* The Hague; Bernard van Leer Foundation.

Roggman, L., Moe, S., Hart, A., & Forthun, L. (1994). Family leisure and social support: Relations with parenting stress and psychological well-being in Head Start parents. *Early Childhood Research Quarterly, 9,* 463–480.

Werner, E. E. (1990). Protective factors and individual resilience. In S. J. Meisels and J. P. Shonkoff (Eds.), *Handbook of early child intervention* (pp. 97–116). Cambridge: Cambridge University Press.

Victimization, Personality Factors, and Coping Strategies in African American Youth

Zina T. McGee

PRESENTER: Zina T. McGee

The degree of victimization experienced by a sample of African American adolescents in an urban setting was measured. Emphasis was placed on the effects of violence by including measures of personality dimensions as moderators of the stress experienced in these urban environments. Linkages between personality and coping among youth are discussed.

(Abstract from original proposal; paper summary not available for publication.)

The Culture of Foster Care: What Are the Children Trying to Tell Us?

Ramona Rukstele, Jeffery J. Lusko

PRESENTERS: Ramona Rukstele, Jeffrey J. Lusko

Popular belief maintains that foster care rescues a child from danger. While there is merit in this belief, the system does not acknowledge the enormity of the experience for children. The way of life that constitutes out-of-home placement from the child's perspective is described. The child's resulting idiomatic views and values of life are also discussed.

(Abstract from original proposal; paper summary not available for publication.)

Head Start Children At-Risk: Relationship of Prenatal Drug Exposure to Emotional and Behavioral Disorders

Esther Sinclair

PRESENTER: Esther Sinclair

The relationship between prenatal drug exposure, emotional and behavioral disorders (EBD) identification in Head Start, and subsequent special education kindergarten placement in a sample of 145 Head Start children was examined. Results showed 47% of the drug-exposed group versus 35% if the non-drug-exposed group met classification criteria for EBD. In addition, 53% of the drug-exposed group were placed into special education kindergarten programs versus 29% of the non-drug-exposed group.

(Abstract from original proposal; paper summary not available for publication.)

Migrant Children of the Road: The Sources and Impact of Social Support

Mary Lou de Leon Siantz, Connie Cabrera

PRESENTER: Mary Lou de Leon Siantz

A self-description of social support for 163 Mexican American children attending the Migrant Head Start program in Texas is provided. The types, degree, and source of social support and the influence of gender, parenting style, and depression has not previously been studied. Differences were found between genders in perception of support. Results are discussed.

(Abstract from original proposal; paper summary not available for publication.)

Methods

Early-Care and Education Program Effects on Primary-Grade Child Outcomes

Sue Vartuli, Helen Brotemarkle, Susan Curtis

PRESENTERS: Sue Vartuli, Helen Brotemarkle

The primary objective of this study was to compare two age groups of low-income children with different early care experiences (center care, family child care, Head Start, or no outside care) on child outcome measures and parent involvement. Two age groups of children were followed from kindergarten to second or third grade. To compare the quality of care, a subset of seven early care and education centers utilized by study children was selected. Observations and interviews were conducted to compare the quality of interactions and the type of services offered families at the seven centers and the Head Start center. It was hypothesized that by second and third grade, the low-income children who attended the various early care experiences would not differ on child outcomes or parent involvement activities.

The Peabody Picture Vocabulary Test-Revised, a test of receptive language, and the Achievement Battery of the Woodcock-Johnson, Revised Edition, Reading and Mathematics Clusters were used to measure child academic outcomes. Children were interviewed by trained data collectors the fall of their kindergarten year and during the spring of their first-, second- and third-grade years. Primary-grade teachers collected individual family involvement activities on the Family Involvement Form throughout the school year. The form was divided into one-way (newsletters, flyers, progress reports, etc.) and two-way (conferences, home visits, school discussions, etc.) communication activities. Actual teacher behaviors were observed using a revised version of the Classroom Practices Inventory.

In the fall of 1992, 176 children and low-income families were interviewed, and in the fall of 1993, 275 children and families were interviewed (50 high-income families were selected to be a comparison group). Information was gathered from both children and families every spring after the initial fall baseline. Teacher observations and interviews were conducted with 16 Head Start teachers and 18 selected center teachers in the spring of 1993. Children, families, and teachers were participants in the Independence, Missouri Public School Head Start Transition Research and Demonstration Project.

The impact of early care and education experiences on school achievement and family involvement in school was examined in this study. The children from the selected centers and the Head Start classrooms had similar quality experiences prior to attending public school. Isolated significant differences did occur in children's tests scores and family involvement scores among the children who attended different types of early care and education experiences prior to starting public school. There was no distinct pattern to the results, except that the children who attended the study center schools had consistently higher scores than the other children. Children from this group, although from low-income families, had quality early care and education experiences prior to school entry and were from a higher low-income group than the Head Start children. The results reveal that there is variability within the low-income group and that the Head Start experience may not be enough to address the needs of the Head Start child and family.

Listening to Children: A New Approach to Parent Education and Support Among Head Start Mothers and Low-Income Mothers of Color

Randi B. Wolfe

PRESENTER: Randi B. Wolfe

Listening to Children (LTC), a parent support and education program based on a unique set of philosophical and methodological underpinnings, has been developed over the past 5 years in collaboration with a university, a school district, a family support center, and a Head Start program. The LTC program has been successfully implemented among economically and racially diverse populations and parents of variously aged children. Quantitative and qualitative evaluations suggest that program participation reduces parenting and family-related stress, improves parental attitudes, and encourages authoritative parenting practices.

The LTC program is based on the theory and practice of re-evaluation counseling, which assumes that people are born with an enormous capacity for intelligent, cooperative, flexible behavior that is diminished and obscured in adults as a result of accumulated distress experiences that begin early in life (Jackins, 1991). It is postulated that if adequate emotional discharge (i.e., crying, laughing) takes place, people recover from the effects of past hurts, become more effective in looking out for their interests and the interests of others, and become more capable of acting successfully against injustice (Jackins, 1994). This emphasis on empowerment and framing individual concerns in a broader social context makes the approach somewhat unique.

The program consists of eight weekly meetings, each built around a theme reflected in the information presented, in-class activities, readings, and homework assignments. Three elements form the core of the intervention and render LTC distinct in its approach to parenting and parent education: (a) understanding and resolving the effects of parents' own childhood experiences so that these early experiences do not diminish present time parenting effectiveness, (b) spending "parent-child special time" as a means of developing mutual trust and encouraging children's capacity for prosocial behavior and academic success, and (c) understanding and handling children's emotional upsets, rather than requiring compliance or obedience.

Three studies have been conducted to determine whether the program is viable, whether it produces measurable effects, whether those effects are sustained over time, and whether the program is effective among diverse populations (Wolfe, 1997). In the first study, middle class, married mothers (n=25) were randomly assigned to a treatment group and an equivalent no-treatment comparison group. Eleven members of the no-treatment group participated in the program several months later. Pretest, posttest, and 3-month follow-up measures included a parental attitude survey and a parenting stress index. Spouses provided additional feedback at posttest and follow-up. The second study was a pretest-posttest design involving 14 low-income, African American mothers from a community family support center. Measures were refined to address the shortcomings of the first study. In the third study, 18 Head Start mothers were assigned to a treatment group and an equivalent no-treatment comparison group. Six members of the no-treatment group participated in the program 2 months later. Added to the measures were a parenting practices questionnaire and qualitative exit interviews. Designated key informants completed research instruments at pretest, posttest, and follow-up.

Across studies, significant effects in the expected direction were observed at posttest and follow-up, although some effects tended to diminish somewhat over time. Results suggest that LTC reduces parenting-related stress, improves parental attitudes, and encourages authoritative parenting practices. The program appears relevant and effective among mothers of various socioeconomic, racial, and cultural groups.

Additional research is needed to distinguish the impact of the program from the impact of

the group leader. Further investigation is necessary to determine whether prolonged involvement in the program would result in sustained effects over time. Behavioral measures are needed to augment the self-report measures.

References

Jackins, H. (1991). *The human situation.* Seattle, WA: Rational Island Publishers.

Jackins, H. (1994). *The human side of human beings.* Seattle, WA: Rational Island Publishers.

Wolfe, R. B. (1997). *Listening to children: Three studies toward developing, evaluating, and replicating a new approach to parent education, support, and empowerment.* Unpublished doctoral dissertation, Northwestern University, Evanston, IL.

Head Start Research Collaboration: Reducing Pesticide Exposure in Minority Families

Linda A. McCauley, Juanita Santana, Marco Beltran, Kent Anger, Marie Napolitano, Joan Rothlein

PRESENTERS: Linda A. McCauley, Juanita Santana

Minority populations are overrepresented in pesticide exposures and bear a disproportionate share of the potential health risks (Moses, Johnson, Anger, Burse, Horstman, Jackson, Lewis, Maddy, McConnell, Meggs, & Zahm, 1993). The largest single group exposed are seasonal farm workers and their children who concurrently have limited access to adequate preventative health care (Wilk, 1988). Research programs are needed to test culturally-relevant strategies aimed at prevention of acute and chronic exposures (Task Force on Environmental Cancer and Heart and Lung Disease, 1990; National Research Council, 1993). The National Institute for Environmental Health Science has funded a 4-year, interdisciplinary, community-based prevention and intervention program focusing on pesticide contamination in agricultural communities. Environmental health researchers have joined with Head Start organizations serving migrant families in the development of this 4-year research project incorporating multiphasic prevention and intervention strategies.

The project is being led by a research advisory board consisting of representatives from the agricultural community, academic institutions, and child and family educational, health, and social services. This is a collaborative endeavor which closely involves the Hispanic migrant community in the design and conduct of the research process from start to finish. The project recruits children and parents from agricultural families being served by the Migrant Head Start programs in rural areas of the northwest United States. The specific aims of the study are:

1. Establish the relationship between levels of pesticides in homes and the type of agricultural crop the parents work with, the types of pesticides commonly used on the crops, proximity of housing to the agricultural fields, and home characteristics including ventilation, size, and traffic patterns.
2. Evaluate specific health outcomes associated with pesticide overexposure in both workers and their children by measuring biomarkers of exposure and markers of neurobehavioral health effects.
3. Assess the effectiveness of the Migrant Head Start program as a mechanism for delivering culturally-appropriate prevention strategies to increase pesticide avoidance behaviors and decrease levels of environmental exposure to pesticides.

The project includes cross-sectional surveys of pesticide use and protection practices, analyses

of home-dust samples for pesticide residues, an assessment of biomarkers of organophosphate exposure and an assessment of effects on neurobehavioral function. The association between pesticide exposures of migrant farm families and factors related to parental occupation, home environment, pesticide drift in homes adjacent to agricultural areas, and pesticide levels in soil and home dust are being analyzed.

Culturally relevant intervention strategies for migrant Hispanic farmworkers and families are being planned, pretested, implemented, and evaluated. Specifically, the research program is designed to test whether intervention programs integrated into established child-focused community organizations are effective in increasing migrant families' knowledge of pesticide safety and behaviors that decrease exposures at work and at home, resulting in decreased risk of exposure to pesticides in the environment and improved health. Changes in health behavior will be assessed by changes in knowledge, cleaning practices, protection practices, and changes in levels of pesticides in the home environment.

References

Moses, M., Johnson E. S., Anger, W. K., Burse, V. W., Horstman, S. W., Jackson, R. J., Lewis, R., Maddy, K. T., McConnell, R., Meggs, R., & Zahm, S. H. (1993). Environmental equity and pesticide exposure. *Toxicology and Industrial Health 9*, 913–959.

National Research Council. *Pesticides in the diets of infants and children.* Washington, DC: National Academy Press, 1993.

Task Force of Environmental Cancer and Heart and Lung Disease. (1990). Baker, S. R., & Wilkinson, C. F. (Eds.). *The effects of pesticides on human health.* Princeton, NJ: Princeton Scientific Publishing Co., Inc.

Wilk, V.A. (1988). *Occupational health of migrant and seasonal farmworkers in the US: Progress report.* Washington, DC: Farmworker Justice Fund.

Scaled Tests Are Inappropriate for Head Start Evaluation

Bernard Brown

PRESENTER: Bernard Brown

The thesis of this paper is that scaled tests have basic flaws that hide program effects and are unsuitable for evaluating Head Start. The basic observed (raw) scores of behavioral tests fully describe a child's responses to test items. They are direct, simple, and sufficient scientific descriptions. In contrast, scaling changes observations of level of ability into an index of rank, relative ability. Observed scores are transformed into scaled scores along an artificial gaussian (bell) curve.

Growth is the quintessential characteristic of children, a central issue in Head Start evaluation, but the scaling process creates a "bad clock," mathematically removing the component of growth from basic measures of cognitive ability. The WISC-R IQ test, for example, separates children into 33 age groups. A child's observed score on the test is then compared to scores of children in the same age group. Scaled scores cannot reveal how mental ability changes with age or identify children who grow fast or slow—or grow longer.

While scaled measures and their statistical analyses are predicated on assumptions of normality, Micceri (1989) found that in practice almost none of 440 large data sets from educational and psychological research showed a normal shape. Test manual tables are generally designed only to describe averages with normal distributions.

The scaling process produces an adjusted measure in order to describe a wide range of

children with a single measure. Averaging obscures real performance differences associated with sex, income, and culture at given ages. Especially at younger ages, an intervention effect for scaled scores comes from the tails of the scaled score distributions. The effect is carried by a small fraction of the sample. The complex and elaborate scaling process filters, mutates, reconstructs, and reframes information from observed scores, distorting basic behavioral observations (Brown, 1997).

There is no theoretical basis for the use of scaled scores in longitudinal studies. Nevertheless, almost all longitudinal studies of the mental abilities of children, including all Head Start studies, have used scaled scores. The means of scaled scores stay constant at 100 for all ages, even though synaptic growth continues and a child's absolute abilities keep growing.

Studies of Head Start have found long-term gains in retention in grade, assignment to special education classes, and school completion; however, initial gains faded by fifth grade (Brown, 1978; Consortium, 1983.) The disparity between strong effects from single event measures and weak effects from scaled tests has been a continuing puzzle.

There are some simple ways to analyze behavioral tests to evaluate Head Start. Observed scores can provide detailed information on the developmental trajectories of Head Start children. Fischer's (1997) non-scaled test of social competence (ages 2–12), based on his dynamic structuralism, measures a child in the context of a task. Head Start provides an environment of optimal task context (high support, familiar tasks, and motivation to perform) compatible with his approach. His tests generate growth curves rich in details of development not observable in minimal support environments.

References

Brown, B. (Ed.) (1978). *Found: Long-term gains from early intervention.* Boulder, CO: Westview Press.

Brown, B. (1997). *Raw scores of cognitive ability are real psychological variables: IQ is a hyperspace variable.* American Psychological Society Annual Meeting.

Consortium for Longitudinal Studies. (1983). *As the twig is bent...Lasting effects of preschool programs.* Hillsdale, NJ: Erlbaum.

Micceri, T. (1989). The unicorn, the normal curve, and other improbable creatures. *Psychological Bulletin, 99,* 282–288.

Fischer, K. W., & Bidell, T. R.(1997). Dynamic development of psychological structures in action and thought. In R.M. Lerner (Ed.), *Handbook of Child Psychology* (5th ed.). New York: Wiley.

The Influence of Management Climate on the Quality of Head Start Programs

Richard G. Lambert, Martha S. Abbott-Shim, Frances A. McCarty, Mary Madden

PRESENTERS: Richard G. Lambert, Martha S. Abbott-Shim, Frances A. McCarty, Mary Madden

The purpose of this study was to investigate whether Head Start teachers agree with their center managers with regard to perceptions of policy clarity and to examine whether the extent of agreement between teacher and manager regarding policy clarity is related to teacher job satisfaction and other teacher perceptions of program quality. This study therefore examined whether dissonance between teachers and center managers with regard to the perceived clarity of program policies could be used as a measure of program quality.

The Policy and Program Management Inventory (PMI) teacher version was used to measure teacher perceptions of the management climate within each center while the administrator version was used to obtain the same perceptions from the center manager. The instrument yields

factor scores in the following areas: (a) communication, (b) workload and self development, (c) hiring and retention, (d) support, and (e) policy clarity. Since teachers and teacher aides (n=141) were nested within center managers (n=23), hierarchical linear modeling (HLM) was used to examine the question of agreement.

The level one model examined whether teacher demographic attributes are related to teacher perceptions of policy clarity in an attempt to adjust for the characteristics of the teachers within each center. Teacher's age, education level, and years of teaching experience were tested with only years of experience exhibiting a statistically significant, though modest relationship with policy clarity (r^2=.04, t=2.29, p=.03), suggesting that as experience increases so does a teacher's understanding of policies. The slope of experience with policy clarity did not show sufficient variability between centers to warrant exploration of a random slopes model.

The level two model examined whether the center mean teacher perception of policy clarity, adjusted for teacher experience, was related to the center manager's perception of policy clarity. There was not a statistically significant relationship between the center manager's response and the adjusted center mean teacher perception of policy clarity. These findings suggest the possibility of substantial disagreement between the staff levels.

A series of subsequent HLM analyses examined the relationship between the teacher and manager's dissonance and other teacher perceptions of program quality. Teacher perception of policy clarity was centered on the center manager's perception of policy clarity and entered as the independent variable in the estimation of each within center level one equation while job satisfaction and the other PMI factor scores were used as dependent variables. The dissonance regarding policy clarity between the staff levels was associated with each of the teacher perceptions of program quality: (a) communication (r^2=.55, t=11.69, p=.00), (b) hiring and retention (r^2=.30, t=7.20, p=.00), (c) support (r^2=.37, t=8.54, p=.00), (d) workload and self development (r^2=.47, t=10.01, p=.00), and (e) job satisfaction (r^2=.06, t=2.83, p=.01). While some of the degree of association between dissonance and these measures was, in part, due to the intercorrelation between the policy clarity factor and the other measures, the dissonance between the center manager and the teacher does appear to be a potential quality indicator worthy of further explanation.

Affective Developmental Pathways: A Study of Mothers and Infants in Early Head Start

Marlene Major Ahmed, Catherine Ayoub, Meredith Rowe, Deborah Schutte

PRESENTERS: Marlene Major Ahmed, Meredith Rowe, Deborah Schutte

Using transcripts and videotapes of dyadic interaction, the methodological aims of the study were: (a) to construct a scheme for coding the expression of primary emotions, the related thematic content, expression of affect, and temperamental style of the young child in interaction with another person (in this case, a caregiving parent); (b) to construct a scheme for coding the expression of emotions, expression of affect, and the engagement and empathic quality of the adult; and (c) to construct a coding scheme that accommodates the socioemotional, temperamental, affective, interactional, and language domains for simultaneous evaluation and comparison.

The study posed the following methodological questions: (a) How does the interaction between the child's temperament, expression of themes and emotions, mother's empathy, and her expression of emotions relate to the interactional patterns between the parent and young child over time (ages 14 months, 24 months, and 36 months)? (b) What is the interaction

between language acquisition and fluency, development of emotions, and social attachment and exchange between mother and child over time? Are the above developmental domains associated with each other, based on characteristics in the mother, the child, or the family? Are there variations in patterns? Are program interventions associated with variation and patterns? and, (c) How do the patterns of interaction between mother and child (and their change over time) impact on the child's language acquisition, emotional development, and cognitive skills?

Videotaped interaction of parent-child dyads at child ages 14, 24, and 36 months were collected in conjunction with the national evaluation of Early Head Start. These interactions were transcribed into the Child Language Data Exchange System. The SEC (Social, Emotional, Cognitive) coding scheme was included in these transcripts, which enables the integration of linguistic and SEC data into one system for joint analysis.

The SEC Coding Scheme was created to capture children's social, emotional, and cognitive growth. Sets of codes were created for both mother and child. The transcription of the videotaped interaction is microcoded by adding tiers for each maternal and child utterance or nonverbal behavior. The child categories of codes and tiers consist of affective tone and expression (%aft), child motor activity (%mtr, %oar), themes represented by child's behavior (%thm), emotions (%emo), and overall child cognitive skill-level (%osr). The maternal categories of codes include affective tone and expression, evidence of engagement toward child (%eng), emotions, and expressed empathy (%oer).

Transcripts of parent-child interaction and videotapes of these interactions provide a rich data source for analyzing within child domains of language, social, emotional, temperamental, and cognitive development as well as interrelationships between the domains as the child changes over time.

The construction of the SEC coding scheme that simultaneously can synthesize information in each of these domains offers the opportunity for analysis of such complex and multifaceted constructs in a uniform way. Using the work in linguistic coding as a base, we have augmented the capacity of the CHILDES system to allow for comparative analysis across these important domains.

The SEC coding system will serve as the basis for mapping the development of the child and the parent-child relationship over time. It will also lay the foundation for assessing variations in patterns of development and skill acquisition of the child in light of an array of early interventions offered to children and families.

Assessing Neighborhoods for Children and Families: A Multimethod Approach

Margaret O'Brien Caughy, Jacqueline Patterson, Patricia J. O'Campo

PRESENTERS: Margaret O'Brien Caughy, Jacqueline Patterson

In this presentation, we reported on the development and implementation of a multimethod neighborhood assessment protocol that can provide program planners as well as researchers with a means of characterizing the community context which impacts children and families. This project is part of a larger research study looking at the effects of neighborhood characteristics on African American families and their preschool children residing in a diverse sample of neighborhoods in Baltimore City. In developing the neighborhood assessment protocol, we drew from Bronfenbrenner's ecosystem model (1979), the cultural ecological model of parenting (Ogbu, 1981), and the "cultural systems paradigm" (CSP; Whitehead, 1992). In our conceptual model, we distinguish five types of neighborhood variables: (a) Physical Features,

(b) Demographic Features, (c) Social and Economic Features, (d) Social Organization, and (e) Social Norms and Culture. Data for the neighborhood-level variables are being obtained from a combination of routinely collected sources and primary data collection. For assessing observable characteristics of the neighborhoods, we used a walk-through methodology to document physical features as well as observable features of social organization based on the work of Perkins, Meeks, and Taylor (1992) and the Project for Human Development in Chicago Neighborhoods (NORC, 1995). A team of two observers conducted the observation for every 100 blocks in each of the 39 study neighborhoods, or approximately 730 blocks. Each observation took 15–20 minutes to complete.

The development and evaluation of community-based initiatives for families and children should incorporate consideration of the neighborhood context in which the initiative will take place. The neighborhood assessment protocol we have developed utilizes easily obtainable data while still providing a comprehensive picture of the neighborhood.

References

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

National Opinion Research Center. (1995). *SSO (Systematic Social Observation) Coding Manual.* Project for Human Development in Chicago Neighborhoods; Harvard Project 4709.

Ogbu, J. U. (1981). Origins of human competence: A cultural-ecological perspective. *Child Development, 52,* 413–429.

Perkins, D., Meeks, J., & Taylor, R. B. (1992). The physical environment of street blocks and resident perceptions of crime and disorder: Implications for theory and measurement. *Journal of Environmental Psychology, 12,* 21–34.

Whitehead, T. L. (1992). In search of soul food and meaning: Culture, food, and health. In H.A. Baer & Y. Jones (Eds.), *African Americans in the South: Issues of race, class and gender.* Athens, GA: University of Georgia Press.

Action Research to Effect Change for Urban Youngsters in Health and Fitness: A School-College Endeavor

Linda A. Catelli, Margaret Franco

PRESENTERS: Linda A. Catelli, Margaret Franco

Research findings and recent literature in education indicate that the health-related fitness status of children in the U.S., in particular urban minority children, fall well below standards set by the medical and health professions (AAHPERD, 1987; Gortmaker, Dietz, Sobol, & Wehler 1987; Gutin et al., 1990; Reiff, 1986; Ross et al., 1987; Simons-Morton, Parcel, O'Hara, Blair, & Pate, 1988; U.S. Department of Health and Human Services, 1996; Wughalter, 1990). Numerous reports and studies by the health professions have reported significant decreases in health and fitness levels—cardiovascular endurance, muscular strength, flexibility, and body fatness—of children and, more importantly, a significant decrease in their activity level (Blair, 1985; 1989; Updyke & Willet, 1989; U.S.-DHHS). Viewed in the past as a geriatric problem, cardiovascular disease, is now recognized as a pediatric problem. Today, we know that, as compared to 20 years ago, younger children weigh more, have more body fat (Ross et al.; Updyke & Willett; U.S.-DHHS), and for a variety of reasons (i.e., television, video games, etc.) have lower health-related fitness and activity levels.

In conducting an investigation and an analysis of the problem, the American Academy of Pediatrics identified schools as being part of the problem. They strongly recommended that

schools actively support school programs that promote life-long habits of health-related exercise. In 1988, the American Heart Association identified the "school-site" as its priority and highlighted "prevention" as a key means of reducing adult cardiovascular disease. In 1996, the Surgeon General's Report concluded that physical activity does decrease the risk of cardiovascular disease and subsequently recommended that schools be key players in promoting health-fitness and physical activity in regularly-scheduled classes (US-DHHS, 1996).

The problem is that there are very few inner-city schools with a curriculum that includes programs in health education (e.g., nutrition and weight reduction) or physical education/ fitness (improving aerobic cardiovascular capacity) that effect significant outcomes for pupils in these areas. This is especially true of inner-city schools that serve ethnically and racially diverse pupil populations. The areas of health and physical education suffer low status within school curriculum and are usually given the least support in monies, personnel, and scheduling. Thus, the action research studies were engaged in an effort to begin to remedy the situation and rectify the present health-related fitness status of urban youngsters. The studies are part of a partnership program entitled Project SCOPE, which has as its overall goal the simultaneous improvement and reform of K-12 schooling and teacher education. More specifically, the action-research studies were conducted by school teachers and college educators/researchers to effect curriculum change and health-fitness improvement for a pupil population enrolled in a New York City public middle school (n=1400).

Findings from the studies were used successfully to initiate, support, and monitor change and improvement throughout the duration of the project. Also, the findings were strategically and effectively presented at school conferences and at meetings held by the school's site-based. management to gain the necessary support for substantial curriculum change and improved fitness experiences for the school's youth.

References

American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD). (November/ December,1987). *JOPERD: National children and youth fitness study II.* [Special Feature]. Reston, VA: Author.

Blair, S. (1985). A total fitness lifestyle. In Candiff, D., (Ed.), *Implementation of health fitness exercise programs* (pp. 7-13). Reston, VA: AAHPERD.

Blair, S. (1989). Exercise and fitness in childhood: Implications for a life-time of health. In C. V. Gisolfi & D. R. Lamb (Eds.), *Perspectives in exercise science and sports medicine: Vol. 2. Youth, exercise, and sport* (pp. 401-422). IN: Benchmark Press.

Gortmaker, S., Dietz, W. H. Jr., Sobol, A. M., & Wehler, C. A. (1987). Increasing pediatric obesity in the United States. *American Journal of Diseases of Children, 141*(5), 535-540.

Gutin, B., Basch, C., Shea, S., Contento, I., DeLozier, M., Rips, J., Irigoyen, M., & Zybert, P. (1990). Blood pressure, fitness and fatness in 5- and 6-year-old children. *Journal of the American Medical Association, 264*(9), 1123-1127.

Reiff, G. (1986). *The President's Council on Physical Fitness and Sports 1985: National school population fitness survey.* Ann Arbor: University of Michigan.

Ross, J. G. et al. (1987). Changes in body composition of children. *Journal of Physical Education, Recreation and Dance, 58*(9), 74-77.

Simons-Morton, B. G., Parcel, G. S., O'Hara, N. M., Blair, S. N., & Pate, R. R. (1988). Health-related physical fitness in childhood: Status and recommendations. *American Review of Public Health,* 9, 403-425.

Updyke, W. F., & Willett, M. S. (Eds.). (1989). *Physical fitness trends in American youth.* Washington, DC: Chrysler - AAU Physical Fitness Program.

U.S.-DHHS, United States Department of Health and Human Services. (1996). *Physical activity and health: A report of the surgeon general.* Atlanta, GA: Author.

Wughalter, E. (1990). *Executive summary report: New York City—Youth Fitness Study, 1989-1990.* New York City: American Heart Association, New York City Affiliate.

Continuous Quality Improvement in Early Head Start: Conducting Self-Assessment Through Parent and Staff Surveys

Jeffrey Roth, Lisa M. Goldman

PRESENTERS: Jeffrey Roth, Lisa M. Goldman

When Head Start's Program Performance Standards were revised and published in November 1996, a central feature of the continuous quality improvement (CQI) process was embedded into the statutory language: "At least once each year, . . . grantee and delegate agencies must conduct a self-assessment of their effectiveness and progress in meeting program goals and objectives" (*Federal Register*, 1996, 57222). Self-assessment is predicated on three CQI principles: (a) those who deliver program services and those who receive program services are together the most knowledgeable sources of information about what the program is doing well and what it is doing poorly; (b) soliciting, summarizing, and acting upon staff and participant impressions of a program's strong and weak points is a highly efficient way for administrators and policy makers to correct problems in program design and execution; and (c) in addition to removing unforeseen obstacles to achieving program objectives, the translation of staff and participant perceptions into revised procedures pays a handsome dividend by eliciting greater solidarity and affiliation with program methods and goals in both constituencies.

Three surveys of parents and staff members were conducted during the second year of a Wave 1 Early Head Start (EHS) grant awarded October, 1995, to the School Board of Alachua County (SBAC) in Gainesville, Florida. A 10-item survey requested parental input into the scheduling and content of monthly parent meetings. A second 45-item survey asked parents to evaluate six components of the EHS program: facility, staff, child's progress and transportation, GED course, WIC, and County Public Health Unit. A third 32-item survey asked EHS staff members to evaluate six program areas: caregivers/teachers, administration, WIC, County Public Health Unit, secretaries and receptionists, and maintenance.

On the survey of content for parent meetings, toilet training technique was the most frequently requested topic for presentation. This request for instruction in basic infant/toddler care suggested a preponderance of first-time mothers. In fact, the SBAC's EHS 1996–97 Program Information Report to ACF indicated that more than 50% of enrolled women were first time mothers. Since nearly three-quarters of the enrolled families were single-parent, it was not surprising that the most frequently requested topic for small group meetings was the single parent home. Family planning was the second most requested topic. On the parent evaluation survey, more than half the respondents reported they were not enrolled in the GED course. One third of the nine adults enrolled in the GED course reported being absent from the course more than 5 days a month. Five of the other six enrollees were absent 2 to 3 days a month. Unlike WIC, in which 90% of the parents participate, the County Public Health Unit was not used by half the parents completing the survey.

On the program evaluation survey completed by EHS staff members, 100% of the respondents awarded either a 1 or 2 (strongly agree or agree) to all positively-worded statements about the job performance of their co-workers with one exception: maintenance staff.

Investigating the causes of parents' underutilization of onsite health care facilities and GED classes as well as staff dissatisfaction with maintenance personnel clearly will be priorities for this project's continuous quality improvement effort. Likewise, scheduling small group meetings on topics of interest to first-time single parents will enhance the program's capacity to meet participants' expressed needs. Surveying participants and staff is a simple, low-cost way to find out what mid-course corrections to program implementation would be beneficial. The process of soliciting and summarizing client and employee perceptions is an essential first step that every EHS site can take to assess its progress toward achieving program goals.

Qualitative Life-History Interview Methodology With Computer Assisted Analysis: Lessons Learned From the Study

Linda M. Jagielo

PRESENTER: Linda M. Jagielo

Historically, research in which Head Start teacher voices are heard discussing their pedagogical rationale is rare. Studies found include information on the CDA process, participation in social change, the impact of Head Start, and teacher values. Few researchers ask Head Start teachers to explicate their life stories or to draw connections between their professional pedagogy and their lived experience. During recent years there has been an increase in attention toward teachers as sources of insight about teaching. It has been said that the kind of teacher one becomes reflects the kind of life one has led. Life history methodologies are useful in accessing conscious and tacit knowledge. Working together to recreate the past and draw conclusions about the influences on teaching practice matches the collaborative spirit of Head Start.

This poster presentation on methodological techniques was based upon a qualitative study of Head Start teachers, which sought to discover their perception of the impact of their life experience (personal, professional, educational, general) upon their professional pedagogy. The study focused on long-term Head Start teachers (16 to 28 years experience), who began their association with the program as parents and lived and worked in the heart of Head Start—the classroom. The intent of the study was to pay tribute through documentation to the long-term, devoted, grassroots, Head Start teachers upon which the program was built. Lessons learned about methodological data collection and analysis techniques, ethical issues, and challenges were explicated.

The researcher was the primary instrument for data collection and analysis. The tools of her qualitative work assisted in the processes, but NO software does this work for the researcher. Data collection included: interviews, observations, documents, oral notes, and the researcher's reflective journal. Data analysis included: computer assistance (The Ethnograph v4.0 and v5.0), voice activated transcription (Dragon Systems Naturally Speaking), constant comparative analysis, portrait construction, and cross-case comparison.

Discussions of problematic areas included "crossing the DOS to Windows bridge", the "overwhelming-ness" of the quantity of data to be analyzed, and deciding to use a Beta version of software. Ethical decisions included disclosure of preliminary findings to participants and the dance between not misrepresenting their story yet delving deeply into what they had said. Enlightenment occurred at moments when the researcher discovered the difference key words in a question made and when new software programs became unambiguous.

Support provided included a semi-structured process for approaching data analysis, manageability of voluminous data, ease in categorizing and manipulating data, ease in sharing information, and the opportunity to compose, create, write, and author in the style most comfortable, conducive, and natural for the researcher—namely, orally.

This presentation described qualitative methodologies that the researcher found beneficial in the interpretative analysis of narrative, contextual data in search of grounded theory on the perceptions female Head Start teachers had about the influence of their life experience upon their professional pedagogy. It appears that additional qualitative research, in which Head Start teachers or other stakeholders are given the opportunity to be heard, could benefit and enhance the literature surrounding this program.

Serving Children With Language Differences and Disorders: A Tri-Agency Effort in Omaha, NE

Ellen L. Jacobs, Tammy Engebretson, Gene Schwarting

PRESENTER: Ellen L. Jacobs

This poster describes a cooperative research effort among the Child and Family Development Corporation (Head Start), Omaha Public Schools, and the University of Nebraska at Omaha. The goal of the research effort is to improve the accuracy of identifying language impairments in culturally and linguistically diverse groups of children. In order to meet this goal, a language screening program was developed that includes an innovative component: the exploration of "KIDTALK," which is a computerized language screening test. KIDTALK stands for Kidtalk Interactive Diagnostic Test of Aptitude for Language Knowledge. It is designed to assess an individual's ability to acquire linguistic features of "KIDTALK," an invented language that consists of linguistic universals and typologically similar properties of the target populations' languages. Results of a preliminary study exploring KIDTALK's effectiveness with Hispanic Spanish-speaking and Caucasian English-speaking 7- and 8-year-olds showed support for the validity of KIDTALK in identifying language impairments in culturally and linguistically diverse groups of children (Jacobs, in press). Implications were that the KIDTALK approach may also be effective with other ages and linguistic and cultural groups of children.

Over the past year, with financial assistance from the University of Nebraska Committee on Research and the American Speech-Language-Hearing Association, we have been exploring the effectiveness of the KIDTALK method when applied to African American, Caucasian, and Hispanic 3- to 5-year-olds. Still keeping with the theoretical principles upon which KIDTALK is based, Jacobs modified the original test in order to make it appropriate for speakers of the African American English (AAE) dialect as well as for speakers of Standard American English (SAE) and Spanish. These modifications included changes to a few items to account for typological differences among AAE, SAE, and Spanish as well as changes to accommodate the younger age group.

We have conducted five pilot studies on modified versions of the original KIDTALK in order to find an appropriate level of difficulty for the Head Start children. The fifth pilot study involved administering KIDTALK to 20 children: 8 African American, 6 Caucasian, and 6 Hispanic. Item analyses of the fifth pilot version revealed that the average level of item difficulty for the total test was 40% (the lower the percent level, the more difficult the item). The level of item difficulty for the RV subtest was calculated at 45%, the EV subtest at 15%, the EM subtest at 28%, and the AVS subtest at 71%. Because those items at the 50% level of difficulty make maximum discriminating power possible, these results indicate that the level of difficulty still needs to be reduced on the EV and EM subtests. To reduce the level of difficulty in future pilot versions, new training components will be added. KIDTALK will be made into a computer-adaptive test that will measure the learning curve as well as provide a final score.

Reference

Jacobs, E. L. (in press). KIDTALK: A computerized language screening test. *Journal of Computing in Childhood Education.*

The Effectiveness of an Intervention for Drug-Using Mothers and Their Children

Christi A.C. Bergin, Asha Patel, Rosemarie Fleitz

PRESENTER: Christi A.C. Bergin

This is an evaluation of an intervention designed to decrease substance use among mothers and to reduce the severity of impairment in their substance-exposed children (birth to 3 years) at a central-city pediatric clinic. The intervention included case management and weekly substance counseling. At 6-month intervals, participating children received a play-based assessment. If delays were identified, the family was invited to a weekly play group where mothers were coached to stimulate development of the child. The staff included two nurses, a chemical dependency counselor, a pediatrician, a school psychologist, a speech pathologist, and an occupational therapist.

Participants in the study were mothers who were impoverished (96%), single (79%), and African American (80%), with an average age of 26. A comparison group was matched to each participant by poverty status, mother's age, parity, infant's age, sex, race, gestation age, and birth weight. Thus, they had comparable levels of social and medical risk, but were substance free.

A comprehensive substance use history, ongoing self-report, and random toxicology screens were obtained by the CCDCIII. A Parenting Stress Index was completed by the mother. The Hawaii Early Learning Profile (HELP), the Test of Sensory Functioning in Infants, and a neurological exam were completed by clinicians at the play-based assessments.

Three forms of data indicate that the intervention was associated with reduced substance use in participants. First, at each follow-up point, women rated themselves as using less substances. Second, comparison of quantity of use at entry and follow-up assessments indicated that 68% of alcohol users decreased use and 88% of cocaine users achieved sobriety. Third, 75% of women increased the number of days of abstinence between substance use.

Two forms of data indicate that the intervention was associated with reduced impairment of the drug-exposed children. First, comparisons of children receiving different amounts of service indicated that children receiving more than 4 hours of intervention became more age appropriate over time in eight domains: perceptual-motor integration, fine motor, expressive and receptive language, social-emotional, sensory functioning, self-help, and cognitive. Second, a MANOVA indicated that at 12 months there was a significant difference between the two groups (comparison vs. participants) on growth parameters and age-equivalent scores from the HELP (Hotellings $T2 = .31$, $F = 5.1$, $p = .03$), but at 24 months the difference was not significant (Hotellings $T2 = .38$, $F = 2.1$, $p = .24$). Thus, substance-exposed children became more age appropriate, closing the gap with non-substance-exposed comparison children, in spite of having the lowest initial status. This is significant because without intervention the gap between typically developing children and children with biological and social risks is likely to grow larger with age.

At entry, a third of the participants had clinically high levels of stress in the parent-child system. However, the more hours of intervention on child-focused issues, the less stress the mother felt ($r = .60$, $p = .004$). This is important because research has shown that high stress is associated with hostile parent-child interaction and predicts abuse.

Social Competence of Head Start Preschoolers and Their Sibling Constellations

Lisa Schwartz, C. Cybele Raver

PRESENTER: Lisa Schwartz

While emerging research has examined the aspects of parenting behavior that predict positive social outcomes in low-income children, many studies have neglected to consider the role of sibling constellations (i.e., family size, birth order, and spacing) on children's social development. In this study, we examined whether low-income preschoolers' social competence was significantly associated with their family size and with their birth order. We specifically examined whether Head Start preschoolers from small families demonstrated more social competence than their classmates from larger families. In addition, we examined whether first-born children demonstrated greater social competence than later-born children. Social competence was indexed as the percentage of time that children engaged in social pretend play with two different peers, whom they liked, across two 10-minute play sessions. The tapes of peer play sessions were coded for duration of social pretend play for each participant. The results of the study revealed that birth order did not play a significant role in predicting social competence. However, the results did provide evidence for a nonlinear relation between family size and social competence. Specifically, children with no siblings participated in greater amounts of social pretend play with a peer than children with siblings. These preliminary findings suggest that future research should consider family size as well as family structure in studying the normative development of children enrolled in Head Start.

"I Am the Robin Hood Type": Prosocial Behaviors in Pre-Adolescent Children

Susan Talley, Christi A.C. Bergin, Lynne Hamer

PRESENTERS: Susan Talley, Christi A.C. Bergin

The purpose of this study was to investigate the kinds of authentic prosocial behaviors engaged in by pre-adolescents. Eight focus groups of 11- to 13-year-olds from diverse neighborhoods were conducted to obtain descriptions of specific prosocial acts of pre-adolescents in their natural settings as perceived by their peers. Results suggest that traditional research has not done justice to the diversity of prosocial behaviors pre-adolescents engage in and has often emphasized behaviors that are not necessarily most salient to pre-adolescents. Key prosocial behaviors included standing up for others, complimenting and encouraging others, helping others develop sports or academic skills, being non-exclusive in friendships, and using humor appropriately. Emotional regulation emerged as a central issue; that is, prosocial children are able to regulate their own emotions and are also able to help others regulate their own emotions. A broader array of authentic behaviors should be included in future research to facilitate understanding of prosocial development in pre-adolescents.

The Relations Among Second Grade Former Head Start Children's Social Efficacy for Peer Interactions, Social Behavior, School Adjustment, and Academic Achievement

Tina M. Younoszai

PRESENTER: Tina M. Younoszai

There is growing evidence to suggest that the relationships children form with peers will affect their social development, adjustment to school, and academic achievement (Ladd & Kochenderfer, 1996; Ladd, Price, & Hart, 1988; Parker & Asher, 1987; Wentzel, 1993). Although research has investigated peer relationships and children's social behaviors from the perspective of children's teachers and peers, little relevance has been placed on the perspective of the child (Wheeler & Ladd, 1982). The purpose of this study was to explore the relationship between second grade former Head Start children's social efficacy for peer interactions, their social behavior, school adjustment, and academic achievement. The congruence between child, teacher, and parent perceptions of children's social efficacy was also examined.

This study is based on data from a Head Start Public School Transition Demonstration. The sample comprised former Head Start second grade children and their teachers and parents completing surveys at the end of the school year. There were 271 children who participated; 144 had parent assessments and 133 had teacher assessments.

Children's social efficacy for peer interactions was obtained using child, parent, and teacher abridged versions of the Social Efficacy for Peer Interaction Scale (Wheeler & Ladd, 1982). Teachers assessed children's social skills and problem behaviors using the Social Skills Rating System (Gresham & Elliot, 1990). Children's school adjustment was assessed by parents using Your Child's Adjustment to School (Reid & Landesman, 1986). Children's academic achievement was assessed by the Peabody Picture Vocabulary Test (PPVT) and Woodcock Johnson reading (WJ-R) and math clusters (WJ-M).

Children rated their social efficacy for peer interactions favorably ($M = 2.74$, $SD = .53$), as did their teachers ($M = 2.88$, $SD = .55$) and parents ($M = 3.09$, $SD = .54$). Child and teacher ratings were found to differ significantly from parent ratings, ($ts[1, 77] = -4.44$ and 2.54, $p < .001$ and .05, respectively); and children's ratings significantly correlated with teachers' ($r = .21$, $p < .05$), but not with parent ratings.

Children's self-perceptions and parent ratings did not significantly correlate with any of the outcomes, although teacher ratings did correlate significantly with several of the outcome measures. Teacher ratings of children's social efficacy for peer interactions related positively with children's teacher-rated social skills of cooperation ($r = .19$, $p < .05$) and assertion ($r = .61$, $p < .001$) and related negatively with their ratings of children's internalizing problem behaviors ($r = -.57$, $p < .001$). Teacher perceptions were not found to correlate with children's school adjustment but did correlate with children's scores on the PPVT ($r = .27$, $p < .01$), WJ-R ($r = .15$, $p < .05$), and WJ-M ($r = .23$, $p < .01$).

Findings suggest that teachers may be better at assessing children's social efficacy. The lack of relationships between children's self-perceptions and the outcomes suggest that children may be slightly off. Future studies need to look at the stability in children's social efficacy throughout elementary school as well as these relations with older children.

References

Gresham, F. M., & Elliot, S. N. (1990). *Social skills rating system manual.* Circle Pines, MN: American Guidance Service, Inc.

Ladd, G. W., & Kochenderfer, B. J. (1996). Linkages between friendship and adjustment during early school transitions. In W. M. Bukowski, A. F. Newcomb, & W. W. Hartup (Eds.), *The company they keep: Friendship in childhood and adolescence* (pp. 322–345). New York: Cambridge.

Ladd, G. W., Price, J. M., & Hart, C. H. (1988). Predicting preschoolers' peer status from their playground behaviors. *Child Development, 59*, 986–992.
Parker, J. G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low-accepted children at risk? *Psychological Bulletin, 102*(3), 357–389.
Reid, M., & Landesman, S. (1986). *My family and friends.* Seattle: University of Washington.
Wentzel, K. R. (1993). Does being good make the grade? Social behavior and academic competence in middle school. *Journal of Educational Psychology, 85*, 357–364.
Wheeler, V. A., & Ladd, G. W. (1982). Assessment of children's self-efficacy for social interactions with peers. *Developmental Psychology, 18*(6), 795–805.

The Development of Preschoolers' Thinking Awareness

Joan N. Brunner, Elsie G.J. Moore, Herbert Zimiles

PRESENTER: Joan N. Brunner

Recent cognitive theories on young children's development of the concept of the mind and its functions have focused on the interaction of developmental and experiential factors in determining the development of children's awareness of their own thinking and remembering. The aim of the present study was to investigate preschoolers' development of the concept of the mind by examining the awareness of thinking and remembering as internal functions of the mind. The major question that guided this research is, "Do preschool children show evidence of a theory of the mind?" Subjects were 40 middle- to upper-middle class preschoolers, who attended two multiethnic preschools on a university campus, and their caregivers.

The study utilized a cross-sectional sequential design to determine if and when 3- to 5-year-old preschoolers become aware of other people's thinking and remembering as well as their own. The children were asked to reveal their knowledge of the mind and its functions by interacting with objects and other people. Specifically, children played picture recognition, hide-and-seek, and matching card games with their caregivers in a familiar setting, and answered questions about particular aspects of the game situation. Then, a researcher asked the children questions about the tasks they completed.

Regression analyses were performed on five subcategories within the 50 questions posed to the children, comparing their appropriate answers with their ages. Boxplots were used to illustrate differences between the three age groups of children. A regression analysis and boxplot were also used to compare the proportions of appropriately answered questions among all 50 questions across age groups, $t(38)=4.27$, $p=.0001$; $r=32.5\%$. Correlational analysis was used to determine the relation between appropriate responses in the five subcategories and the 50 questions to the children's ages.

Based on the findings, the following implications for caregivers were suggested: (a) do not underestimate preschoolers' thinking awareness, (b) encourage preschoolers to answer "why" questions about their actions and utterances so they can not only learn, but also interpret new information, and (c) develop a mutual understanding of thinking and remembering with children, and learn to treat children as thinkers whose opinions count.

Measuring Language Development in Children Attending Head Start

Judy K. Montgomery

PRESENTER: Judy K. Montgomery

Impairment of speech and language is the most frequently identified disorder, and speech and language development the most commonly used corresponding special education category, in Head Start programs. This is due in part to the fact that most children with developmental disabilities also exhibit speech and language disorders or some type of communication delay. In addition, most developmental inventories of children ages 3 to 5 tap numerous communication skills.

Speech and language assessment and intervention are also the two most common special education services provided for children in Head Start programs. Assessments are conducted using standardized tests of communication development and some ecological, or context imbedded, tools. The need for intervention, however, is based primarily upon a child's performance on standardized tests of communication development. The degree of improvement after therapy and follow-up recommendations for continued service in school or health care programs are also based on standardized tests.

About 10% of Head Start children are identified for special education services. The remaining 90% of children are typical learners and enhance their language in the daily programming. The average improvement in, or development of, communication skills of these typical Head Start children over a 6-month period of time is not known. What changes occur due to Head Start enrollment, and what improvements occur due to therapeutic intervention are debated. The norms of standardized preschool tests do not include large numbers of Head Start children. Therefore, use of these tests to measure change has been questioned. In order to determine effective interventions for Head Start children with communication disorders, we need to know the expected rate of language growth for these students after 6 months of Head Start attendance.

As we all endeavor to utilize treatment outcomes data to measure our effectiveness, we must be able to answer the question of how much change occurs directly from therapy. How much does this change cost? Is one type of therapy more effective than another, such as pullout, collaboration, or inclusion? What are the preferred practices in speech language therapy when the results are measured against typical language growth?

A study of 45 African American children in an inner-city Head Start program was conducted in 1996 and 1997. Standardized tests were used to measure language change over a 6-month period for nonidentified students. The tools selected were the Peabody Picture Vocabulary Test-3, the Expressive One Word Vocabulary Test-R, and the Clinical Evaluation of Language Fundamentals-P.

Although month-for-month growth was anticipated for typically developing children, this target was exceeded in this culturally diverse group of children. The data showed expressive language increases of 6.5 scaled score points and 5.0 points in receptive language for typical Head Start children. Standard scores were not expected to change, although this group did appear to have acquired more than the anticipated language skills in the 6-month period, thus demonstrating an increase in standard scores. This finding offers a benchmark for normal language growth in Head Start by which we can measure the effectiveness of therapy, therapeutic approaches, and the intensity and frequency of language intervention in this population.

Multiple and Overlapping Disadvantages Among Children

E. Michael Foster, Frank F. Furstenberg Jr.

PRESENTER: E. Michael Foster

Using national data (n >8,000) from the Panel Study of Income Dynamics spanning nearly three decades, this paper describes long-term trends in the well-being of at-risk children. What distinguishes this work from prior research on trends in childhood disadvantage is its emphasis on multiple and overlapping disadvantages. This emphasis reflects work in developmental psychology by Rutter, Sameroff, and others suggesting that children facing multiple risks are especially prone to later problems (Rutter, 1979; Newcomb, Maddahian & Bentler, 1986; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987a; Sameroff, Seifer, Zax, & Barocas, 1987b; Sameroff, Seifer, Baldwin, & Baldwin, 1993; Williams, Anderson, McGee, & Silva, 1990; Liaw & Brooks- Gunn, 1994; Thornberry, Huizinga, & Loeber, 1995; Furstenberg, Cook, Eccles, Elder, & Sameroff, 1999). Given a framework that suggests that disadvantages are cumulative, it is surprising how little is known about the co-existence of social and economic risks among children nationwide. This paper fills that gap and provides new insight into the nature and consequences of childhood disadvantage.

The analyses focus on children experiencing four family disadvantages: poverty, welfare receipt, female headship, and parental joblessness. Of particular interest are the "most disadvantaged"—children who experience all four. This research examines the percentage of children experiencing multiple disadvantages, their racial composition, and the neighborhoods in which they live.

Our findings shed new light on long-term trends in disadvantage, particularly in the gap between African American and White children. Unlike poverty rates, tabulations of multiple disadvantages indicate substantial deterioration in the position of African American children, both in absolute and relative terms. From the late 1960s to early 1990s, the proportion of African American children living in a most disadvantaged family increased by more than 70% (from 11% to 19%). At the same time, the proportion of White children living in such families hovered at a minuscule level. Additional analyses indicate that much of this growth has occurred among preschoolers. Childhood disadvantage may be especially damaging to young children, and if so, the increasing concentration of disadvantage among the very young is especially troubling.

Our analyses also shed light on trends among the population of Head Start enrollees. Our findings suggest that while the poverty rate of Head Start enrollees has fallen slightly, the extent and intensity of disadvantage among enrollees has increased. The proportion of African American enrollees who are most disadvantaged, for example, rose from 26% to 33% between 1983 and 1992. At the same time, the average African American Head Start enrollee now lives in a poorer neighborhood. The average neighborhood poverty rate rose from 27% to 34% during this same period.

Our findings also indicate that while poverty rates suggest that African American and White enrollees are similar, the former are far more likely to live in highly disadvantaged families and in poor neighborhoods. From this perspective, one can see a potential explanation for racial differences in the long-term impact of Head Start. Multiple disadvantages may moderate the impact of Head Start, and the gap in multiple disadvantages—and not race per se—may explain why the benefits of Head Start 'fade-out' over time among African American children.

References

Furstenberg, F. F., Jr., Cook, T. D., Eccles, J., Elder, G. H., Jr., & Sameroff, A. (1999). *Managing to make it: Urban families and adolescent success.* Chicago: University of Chicago Press.

Liaw, F. & Brooks-Gunn, J. (1994). Cumulative familial risks and low-birthweight children's cognitive and behavioral development. *Journal of Clinical Child Psychology, 23*(4), 360-372.
Newcomb, M. D., Maddahian, E., & Bentler, P. M. (1986). Risk factors for drug use among adolescents: Concurrent and longitudinal analyses. *American Journal of Public Health, 76*, 525-530.
Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M. W. Kent and J. E. Rolf (Eds.), *Primary prevention of psychopathology: Social competence in children* (pp.49-74). Hanover, NH: University Press of New England.
Sameroff, A. J., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987a). Intelligence quotient scores of 4-year-old children: Social and environmental risk factors. *Pediatrics, 79*, 343-350.
Sameroff, A. J., Seifer, R., Zax, M., & Barocas, R. (1987b). Early indicators of developmental risk: The Rochester Longitudinal Study. *Schizophrenia Bulletin, 13*, 383-94.
Sameroff, A. J., Seifer, R., Baldwin, A., & Baldwin, C. (1993). Stability of intelligence from preschool to adolescence: The influence of social and family risk factors. *Child Development, 64*, 80-97.
Thornberry, T. P., Huizinga, D., & Loeber, R. (1995). The prevention of serious delinquency and violence: Implications from the program of research on the causes and consequences of delinquency. In J. C. Howell, B. Krisberg, J. David Hawkins, & J. J. Wilson (Eds.), *Sourcebook on serious violent and chronic juvenile offenders.* Thousand Oaks, CA: Sage Publications.
Williams, S., Anderson, J., McGee, R., & Silva, P. A. (1990). Risk factors for behavioral and emotional disorder in preadolescent children. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*, 413-419.

Emergent Literacy Programs in Pediatric Clinics: Volunteer Recruitment and Training

Sharon Dabrow, Linda Grant, Ann Hazzard

PRESENTER: Ann Hazzard

The goal of emergent literacy programs in pediatric clinics to increase shared reading experiences between parents and their young children will be discussed. Volunteers, who read with families in the waiting room are a key component. Volunteers include college students, foster grandparents, medical students, and high school volunteers with the American Red Cross. The goals of training, such as focus on literacy milestones, developmentally appropriate reading materials and techniques, and cultural sensitivity, will be examined.

(Abstract from original proposal; paper summary not received for publication.)

Mastery Motivation, Self-Regulatory Skills, and Scholastic Competence in Economically Disadvantaged Preschoolers

Carolyn D. Boyles, Garrett Lange, Dale C. Farran

PRESENTERS: Carolyn D. Boyles, Garrett Lange, Dale C. Farran

Presently, there is little research on the role of motivation for young children's school achievement, particularly among children from economically disadvantaged homes. Moreover, there is some recent evidence that shows that connections between motivation and early academic skills, where reliable, tend to be quite low and that SES differences in 4-, 5-, and 6-year-old children's academic skills cannot be accounted for by motivational differences (Stipek & Ryan, 1997). The present research was designed to examine the influences of observed and teacher-rated measures of motivation and self-regulatory skills on the scholastic competence of Title 1 pre-kindergarten children from low-income families. The study was conducted as part of a 3-year longitudinal investigation of at-risk children's school-related mastery behaviors. Our specific aims were to (a) to examine the extent that at-risk young children engage in goal-directed mastery activities and use strategy behaviors during free-choice activity periods in classrooms, (b) determine whether observed and teacher-rated motivational differences influence children's scores on concurrent tests of scholastic competence, and (c) determine whether differences on these measures are better predicted by the maturity of the children's self-regulatory skills than by observed and rated measures of motivation.

The participants were 73 Title I pre-K children (*mean CA*=56 mos.) recruited from 5 classrooms in 5 public elementary schools serving a moderately-sized Southeastern metro area. Forty-six children were African American, 13 were White, and 14 represented other racial/ethnic groups. Each child was observed in the classroom on three occasions (9 minutes each) equally spaced over the spring term. Goal-directed mastery behaviors and strategy behaviors were coded during the observations. "Follows-plan" behaviors were also coded to assess emergent strategy use in the children. Tests of early academic abilities were administered individually and included the Test of Early Math Ability (TEMA), Test of Early Reading Ability (TERA), and the Peabody Picture Vocabulary Test (PPVT). Teachers completed a rating scale (COMPSCALE; Lange & Adler, 1997) containing 18 descriptors of children's mastery-related motives, self-regulatory skills, and other instrumental behaviors.

The results of the study showed that children spent large amounts of free-choice classroom center time engaged in object play activities (62.5%). Much less time was spent in focused exploration (15.4%) and goal-directed mastery activities (7.6%) such as puzzles, matching, and sorting tasks. Mature strategy behaviors (organizing materials planfully, self-monitoring task behavior, and asking for help) occurred rarely (approximately 1% of each observation period), but were four times more frequent for children engaged in goal-directed mastery activities than for those engaged in object play activities and were positively related to the children's achievement test scores. Children's "follows-plan" behaviors were observed nearly 30% of the time in goal-directed mastery activities, but less than 5% of the time in object play activities. Teacher ratings of self-regulatory skills (e.g., the propensity to plan, complete tasks, and use external resources spontaneously) more consistently predicted early scholastic performance on the TERA and TEMA than motivational measures.

References

Stipek, D. J., & Ryan, R. H. (1997). Economically disadvantaged preschoolers: Ready to learn but further to go. *Developmental Psychology, 33*(4), 711–723.

Lange, G. W., & Adler, F. (1997, April). *Children's mastery orientations and school achievement in the elementary grades.* Presented at the meetings of the Society for Research in Child Development, Washington, DC.

Using Longitudinal Head Start Data to Examine the Predictiveness of Mother Characteristics on Child Outcomes: Findings From the Head Start Success Study

Mark S. Innocenti, Matthew J. Taylor

PRESENTERS: Mark S. Innocenti, Matthew J. Taylor

In Head Start classrooms around the country, areas have been identified where established educational interventions may be modified. There are currently a number of projects designing, implementing, and evaluating these modifications. However, the interventions are not based on data from Head Start populations but on information collected from other, similar, populations. The Head Start Success Study, funded as a Head Start correlates study by the Administration for Children, Youth, and Families, was designed to identify the factors that predict positive and negative outcomes within a Head Start sample. Following Lorion's model (1989), these factors could then be used to develop interventions specific to Head Start.

Over a 5-year period, the Head Start Success Study followed 248 Head Start children and their families, enrolled in three cohorts across successive years, from first grade to third grade. The project was conducted in collaboration with the Head Start grantees and local education agencies in Salt Lake City, Utah. Extensive information was collected on child, school, maternal, and family variables. Descriptive information was presented on the sample of children and families involved in this project. Structural equation models examining maternal predictors of positive outcomes for children during their Head Start and first grade years were also included. Impacts on Head Start intervention practices were identified.

Measures for this study included a wide variety of questionnaires and standardized individual instruments. Although not all descriptive data can be presented in this summary, interesting findings from the Head Start year include: child cognitive skills and school readiness skills were low when children entered Head Start and remained relatively low upon exit as well (26th to 37th percentile and 21st to 22nd percentile, respectively). Children scored high in classroom problem behaviors (97th percentile) and low (30th percentile range) on various social skills measures. Families scored high in stress and low in resources (79th and 28th percentile).

Confirmatory factor analysis was employed to identify a mother and child measurement model using data collected for the project during the Head Start year. Structural equation models, examining how maternal characteristics predict child factors during the Head Start year, were of interest to researchers as they highlighted the importance of maternal nurturance characteristics on positive cognitive and social skills in children. Structural equation models that examined the predictability of maternal characteristics on child factors over time were also presented. An interesting early finding was that maternal involvement in the Head Start program was found to be a strong predictor of a child's intellectual, academic, and social skills in first grade. This presentation also included a discussion of the implications of these findings on Head Start educational interventions and the study's implications for future research.

The Development, Implementation, and Evaluation of a Culturally and Linguistically Appropriate Curriculum for Limited English Proficient Hispanic Preschoolers in Head Start

Collette Leyva, Salvador Hector Ochoa, Laurie Weaver, Nell Carvell

PRESENTERS: Salvador Hector Ochoa, Nell Carvell

The purpose of this presentation is to discuss the development, implementation, and evaluation of a culturally and linguistically appropriate curriculum for approximately 90 limited English proficient preschoolers in a Head Start center in its first year of operation.

Subjects included 90 students of Mexican American descent attending a Head Start center in north Texas. The students ranged in age from 3 to 5. The majority of the participants were from low-socioeconomic backgrounds. These 90 students were assessed and placed into one of the three groups: (a) English dominant (n=26), (b) Spanish dominant (n=22), and (c) Mixed dominance/undeterminable dominance (n=41). One student was unable to be assessed due to frequent absences. Eighty-two participants were reassessed for posttesting. There was an attrition of 7 students due to students moving or being absent on a frequent basis.

The Preschool Language Scale-3 (PLS-3) and the Pre-Idea Proficiency Test (Pre-IPT) were used to assess the subjects' language proficiency during pretesting. The PLS-3 separates language into the auditory and expressive domain, and provides a standard score in both English and Spanish for preschool children. The Pre-IPT is a game-like instrument that classifies the preschooler into one of three proficiency designations in both English and Spanish: (a) non-speaker, (b) limited speaker, and (c) fluent speaker. For posttesting, both instruments were given in English and Spanish to children in the Spanish dominant and Mixed dominance groups while students in the English dominant group were given only the English version of the PLS-3 and Pre-IPT.

Each of the students was assessed in their perceived dominant language followed by testing in the other language. The testing took between 30–40 minutes depending on their current level of proficiency. Pretesting occurred in August and September, 1997. Posttesting occurred in May, 1998.

Examiners were school psychology doctoral students and graduate students in special education at Texas A&M University. All examiners were skilled in the assessment of children and received training on how to administer both instruments. Each examiner passed an administration proficiency checkout prior to assessing students.

The curriculum used at the Head Start Center was the Language Enrichment Activities Program (LEAPS) in Spanish. The LEAP curriculum was developed by Dr. Laurie R. Weaver based on a program developed by Ms. Nell Carvell. The implementation of the curriculum was evaluated according to the three groups: (a) English dominant, (b) Spanish dominant, and (c) Mixed dominance/Undeterminable dominance.

The pupils in the English-dominant group, collectively, evidenced growth in their English language skills as indicated by a change in their PLS-English mean scores from 85.52 to 88.00. This increase, however, was not statistically significant (t=.888, df=22, p=.384). When examining the results on an individual basis by comparing Pre-IPT scores from pre to posttesting, 10 of the 24 students (42%) improved to a higher level of English proficiency. Thus, across both measures utilized in this study, children in this group evidenced growth in their English language skills.

The students in the Spanish-dominant group collectively evidenced growth in their English language skills as indicated by a 13-point increase in their PLS-English mean scores from 50.00 (basal score) to 62.90. This increase is statistically significant (t=5.472, df=20, p=.00). Simultaneously, pupils collectively evidenced a decrease in their Spanish language skills as indicated by an approximate 6-point drop in their PLS-Spanish mean scores from 82.52 to 76.76. This decrease is statistically significant (t=2.171, df=20, p=.042). When using the Pre-IPT to examine growth on an individual basis, 17 of the 21 children (81%) improved to a higher level of English

proficiency, while 4 (19%) stayed on the same level of English proficiency. The results indicating growth in English are consistent across both measures. However, the results are inconsistent across both measures with respect to Spanish language skills. The PLS indicates a significant decrease while the Pre-IPT states that 80% who had room for growth on this measure increased their level of Spanish proficiency.

The students in the Mixed-dominance group, collectively, evidenced statistically significant growth with respect to their English skills (t=2.311, df=37, p=.027) and a statistically significant decrease in their Spanish skills (t=3.304, df=37, p=.002). There was a 5-point increase and decrease in their English and Spanish mean scores, respectively. On the Pre-IPT, 15 of the 37 (41%) improved to a higher level of English proficiency, and with respect to Spanish proficiency on the Pre-IPT, 7 out of 37 (19%) improved to a higher level. The results are consistent across both measures for both English and Spanish.

Components of Empathic Expression in 2-Year-Old Children

Maureen Crowley, Nancy Keefe, Nancy Marshall, Wendy Wagner Robeson, Ann Marie White

PRESENTERS: Maureen Crowley, Nancy Keefe, Wendy Wagner Robeson, Ann Marie White

Empathic expression in 24-month-olds and the factors that influence this expression will be examined. Analyses show that there are three components to an empathic act: emotional arousal, concern for others, and prosocial acts.

(Abstract from original proposal; paper summary not received for publication.)

Peer Influences on the Academic Achievement of Resident Head Start Graduates

Laura M. Diaz, Norman F. Watt

PRESENTERS: Laura M. Diaz

Academic achievement among low-SES, ethnic-minority adolescents who are Head Start graduates will be examined. Characteristics of target children and of the peer environment will be examined as predictive of academic achievement in high-achieving and low-achieving children. Closeness to friends and need for acceptance by peers are offered as potential mediators.

(Abstract from original proposal; paper summary not received for publication.)

Parenting, Parent Education, and Parent Involvement

Former Head Start Childrens' and Parents' Beliefs About Parents' Participation in School-Related Activities: Relationship to School Adjustment, Child Efficacy, and Child Achievement

Alice R. Galper, Kristin Denton, Carol Seefeldt, Tina Younoszai, Nancy Goldsmith

PRESENTERS: Alice R. Galper, Kristin Denton, Carol Seefeldt, Tina Younoszai

As part of a larger intervention study designed to facilitate the transition of Head Start children into kindergarten and the early elementary grades, we assessed childrens' beliefs about their parents' involvement in 288 former Head Start children now in second and third grade and related these beliefs to: (a) children's school adjustment, (b) children's sense of efficacy for learning, and (c) children's achievement. We also examined the beliefs of 114 parents as they related to the same variables. The sample is ethnically and racially diverse.

There were no significant relationships in third grade children. However, second grade children's beliefs about their parents' home-based involvement related significantly to children's sense of efficacy for learning and children's achievement as measured by both the Reading and Mathematics clusters of the Woodcock-Johnson-Revised (Woodcock & Johnson, 1989). There were no significant relationships between children's beliefs about their parents' school-based involvement, the importance of parents involvement, and any of the other variables.

For third grade children, parents' reports of their own involvement in school-based activities related significantly to children's achievement as measured by the Reading cluster of the Woodcock-Johnson-Revised. For second grade children, parents' reports of their involvement in school-based activities related significantly to children's abilities as measured by the Peabody Picture Vocabulary Test-Revised (Dunn & Dunn, 1981).

Since research on young childrens' beliefs about their parents' involvement in school is difficult to uncover, this study provides a beginning in probing childrens' beliefs about their parents' involvement in school. It is interesting that these children perceived and reacted to their parents' school-related behavior in the home, but not their parents' direct participation in school. In fact, in almost all cases, childrens' beliefs about their parents' direct school involvement were negatively correlated with other variables though not significantly. In contrast to the findings for children, parents' reports about their direct school participation, rather than home-based participation, were related to achievement in both first and second graders, which is consistent with other studies that demonstrate the positive effects of direct parent involvement in children's schooling.

References

Dunn, L. M., & Dunn, L. M. (1981). *Peabody Picture Vocabulary Test-Revised.* Circle Pines, MN: American Guidance Service.

Woodcock, R. W., & Johnson, M. B. (1989). *Woodcock-Johnson Tests of Achievement-Revised.* Allen, TX: DLM Teaching Resources.

Living With Children Who Are Hard-to-Manage: Mothers' Perspectives

Marian B. Phillips, Sharon Judge

PRESENTER: Marian B. Phillips

The purpose of this qualitative study was to gain understanding of the experiences of mothers living with children who are hard-to-manage. Through increased knowledge of what it is like to live with these children, those in positions to aid the family, such as mental health workers, counselors, and educators, may be more effective in early intervention efforts, which, in turn, may enhance children's potential for positive future outcomes.

Fifteen mothers were selected based on the following criteria: (a) her child was enrolled in Head Start and was engaging in hard-to-manage behavior that had been noted as problematic for a minimum of 4 months, (b) the problematic behavior was documented through reports of parent-teacher conferences and results of the Head Start Child Observation Form, and (c) the mother was in agreement that her child was engaging in disruptive behavior.

The data collection process included conducting two interviews and a 30-minute videotaped segment of the mother and child engaging in routine activities, such as play time or snack time. In addition to the two interviews with each mother, 6 of the original 15 mothers were interviewed a third time and three 2-hour home observations were conducted. The total time involvement with each participant ranged from 3–4½ hours for nine mothers and 11–13 hours for six mothers.

Using a symbolic interactionist framework, the findings suggest three phases that mothers move through as they try to make sense of their lives. The first phase focuses on the mothers' interpretations of interactions centered around the children's misbehavior. As the mothers discussed with researchers the negative interactions with their children and others, six themes emerged as common to all and suggest that the mothers' perception is that they are imprisoned by the children's misbehavior. The six themes are: loss of freedom, loss of control, involvement in intervention, feelings of isolation, development of coping strategies, and hypervigilance.

The second phase centers around the mothers' struggle with their identity of self as parent. Positive interactions with their children and brief moments of satisfaction with their parenting behaviors, when compared with other mothers, contribute to their self-perceptions of being "good parents." However, the culmination of actions and interactions with others, their interpretations of those actions, and negative interactions with their children result in the mothers' perceptions of themselves as "bad parents." This then leads to feelings of guilt and self-doubt.

In the third phase, the mothers seek understanding of the misbehavior and search for ways to resolve the conflict they feel in their identity as parents. They move through an internal and an external process in an attempt to resolve the dissonance of the polarity of good and bad parent. In the internal process, they seek understanding of the cause of the children's misbehavior. In the external process, the mothers search for resources to assist them in managing the child's misbehavior.

The following recommendations evolved from the study: (a) focus on family strengths, (b) build and maintain supportive relationships, (c) work toward a holistic approach to delivery of services, (d) establish support groups run by mothers of hard-to-manage children, (e) establish a system of telephone partners, and (f) develop special interest groups among the mothers.

Developmental Gains After Short-Term Parent Training in an Ethnically Diverse Population of High-Risk Infants

June B. Pimm, Maria Calejo, Charles R. Bauer

PRESENTER: June B. Pimm

The importance of parents as teachers of their children has been recognized by several investigators who believe that parents are their children's first and best teacher and that parents must be involved with their children in order for them to learn. The present study investigated the effect of teaching parents to teach their children developmentally appropriate skills. High-risk infants attending an Evaluation and Intervention Program (EIP) at the University of Miami Mailman Center for Child Development were offered the opportunity to participate in parent training. The program focused on teaching parents to incorporate developmental activities into their daily household routine. Monthly, center-based, 45-minute sessions with parent and child were supplemented by telephone follow-up and mailings of developmental materials. The EIP program serves a population that represents multiple ethnic backgrounds as well as the combined effects of socioeconomic risk and medical risk, including prematurity.

The program identifies at birth infants who are considered at the highest risk for developmental delay and provides routine multidisciplinary assessment and follow up beginning in the Neonatal Intensive Care Unit (NICU) and continuing until at least 3 years of age. Follow-up assessment instruments used by the EIP program at the time of the study included the Bayley Scale of Infant Development (original edition) until 30 months of age and the Stanford Binet through 36 months. One hundred and forty-nine parents were offered the opportunity to participate in the intervention. Thirty-nine of these children were accepted into the state-funded early intervention program before participating in the EIP intervention, and 40 were lost to follow-up or parents refused intervention. The study group consisted of the remaining 70 mothers and children. Of these, 15 participated in the intervention for two sessions or less (noncompliant) and 55 participated for three sessions or more (compliant).

Data analysis consisted of comparisons of pre- and postintervention developmental scores of the compliant versus the noncompliant group. Compliant and noncompliant groups did not differ in age, ethnic background, or mental development score prior to intervention. Repeated measures analysis of variance showed a significant interaction effect for compliance and intervention ($p<.01$). Matched pairs t tests showed a significant increase in Bayley scores for children of compliant mothers (pretest 79.36 - posttest 82.58, $p<.05$). For children of noncompliant mothers, there was a reverse effect with scores dropping over time (pretest 80.20 - posttest 73.66, $p<.03$). The percentage of children who scored within the "normal" range on the Bayley posttest was 25% for the noncompliant group and 47% for the compliant group (Chi sq. $p<.05$). These results suggest that a modest intervention program that provides mothers with developmentally appropriate materials and instruction can have a positive effect on mental development in a population where these scores typically go down over time.

Assessing Different Types of Parental Involvement and Home-Literacy Environment

Margaret D. Schultz

PRESENTER: Margaret D. Schultz

Four measures of parental involvement were compared in the prediction of children's preliteracy and language skills. Head Start teacher ratings produced two of the measures: a measure of parental involvement at the level of center activities and a measure of parental involvement at the level of the individual child. Parent questionnaires produced the two other measures: a measure of the literacy environment in their home and an indirect measure of reading frequency. The indirect measure of reading frequency designed specifically for this study included picture books that are best sellers and "foils," or fake books, that the parents were meant to identify as having read to their children or not. While controlling for the children's receptive language ability, we found that the parents' scores on the book identification task were significantly related to the children's preliteracy skills and that there was a trend for parental involvement at the level of the individual children to be negatively related to the children's preliteracy skills. However, parental involvement at the center level and the parent's report of the literacy environment were not related to the children's preliteracy scores.

The findings indicate that parental involvement at the level of individual children is negatively related to children's preliteracy skills. Negative correlations between parental involvement and children's achievement have been documented previously in the parental involvement literature (Hoover-Dempsey, Bassler, & Brissie, 1992). The most frequent explanation for these findings is not that there is something harmful about the involvement that is causing the children to score lower, but that there is a sort of selection bias occurring where the children who have the most difficulty receive higher levels of parental involvement.

It is also interesting that our proxy measure of reading frequency, the book identification task, was significantly related to the children's preliteracy skills while the factor score derived from the parents' self-report of the home literacy environment was not. Two explanations for this finding are possible. First, perhaps the quantity of reading is not as important a predictor as the quality. In asking how frequently the parents read to their children and how many books they have at home, we are not addressing quality issues. However, since our proxy measure consisted of best sellers, perhaps it is tapping into a measure of quality as well. Second, the self-report measures are vulnerable to social desirability which would lessen the reliability of the measures.

Overall, the findings allow us to make some specific suggestions in the assessment of parental involvement and home literacy. First, researchers should design measures of parental involvement that are specific to their research questions, whether they are interested in parental involvement at the center level or at the level of the individual child. Second, intervention studies need to be conducted manipulating different aspects of parental involvement. Third, measures of home literacy should include some indirect measures or checks on the quality of the reported home literacy.

Reference

Hoover-Dempsey, K. V., Bassler, O. C., & Brissie, J. S. (1992). Explorations in parent-school relations. *Journal of Educational Research, 85*(5), 287–294.

What Do Parents Think About Teaching Math to Kindergarten Children?

Belinda Blevins-Knabe, Linda Musun-Miller

PRESENTER: Belinda Blevins-Knabe

During the preschool years, many informal math concepts develop and the stage is set for later connections with formal math concepts taught in school. We were interested in parents' beliefs about teaching children math because parents are a major influence on the academic socialization of young children (Murphy, 1992).

The sample consisted of 61 parents (47 mothers and 14 fathers; 26 were African American parents and 34 were European American parents). They had a total of 49 children (mean age: 5 years 7 months) enrolled in kindergarten. The children were given the Test of Early Mathematics Ability (TEMA-2; Ginsburg & Baroody, 1990).

Parents were asked several open-ended questions. In response to: "How would you help a second- or third-grader who solved a multiplication problem incorrectly?" only 7% of the parents said that they would first figure out how the child was solving the multiplication problem and then try to help the child. The rest said they would simply show the child the correct steps in multiplication. When asked, "What would you say to a preschool child who asked you what is the biggest number?" the majority of parents (59%) said that they would tell their child there was a biggest number. Perhaps parents did so because they were trying to make the concept more easily understood by a child. In order to test this prediction, we asked parents what they would tell an adult who asked whether there was a biggest number. Many parents (48%) would tell an adult that there was a biggest number, while 36% would label or describe the concept of infinity, and 5% would give an example based on experience. Although most parents gave incorrect explanations of infinity, 70% of them did provide explanations to the adult and child that were different in some way suggesting that they were trying to adjust their answer to the child's level. When parents answered the question about how to prepare a child for math in first grade, counting (67% of parents) was the most frequent activity mentioned.

Parents were also asked to describe their own early experiences in math. Many responses were either negative (26%) or neutral (20%), 13% described both positive and negative experiences, and 35% described positive experiences. Father's descriptions of math experiences were correlated with children's math performance.

These interviews indicate that parents think of math as consisting of certain procedures. Parents say they would help a child having trouble with a multiplication problem by giving the child the correct procedure and they do not mention trying to attach the information to what the child knows. The most frequently mentioned activity for preparing a child for first grade was counting. This emphasis on counting may mean that parents are not sensitive to the presence of math in many daily activities. Parents may also lack certain math concepts, such as infinity, themselves. Those who are working with parents should be aware that many parents remember past experiences with math negatively and may need both encouragement to engage in math activities with their child as well as ideas about math concepts and strategies for teaching them.

References

Ginsburg, H., & Baroody, A. J. (1990). *Test of Early Mathematics Ability* (2nd ed.). Austin, TX: Pro-Ed.

Murphy, D. (1992). Constructing the child: Relations between parents' beliefs and child outcomes. *Developmental Review, 12*, 199–232.

Assessing Parent Participation and Change in Family Literacy Program Components

Dionne R. Dobbins, Barbara H. Wasik, Suzannah Herrmann, Wendy K. K. Lam

PRESENTERS: Dionne R. Dobbins, Suzannah Herrmann, Wendy K. K. Lam

Family literacy programs have emerged from the belief that more enduring gains for children exist if early intervention programs involve parents as active participants in their child's learning. In addition to enhancing the literacy skills of children, family literacy programs also work to address the literacy, parenting skills, and social support needs of parents. As a result of participation in family literacy programs, parents are expected to enhance their own literacy skills, enhance their employability, better understand their child's development, and help prepare their children for learning in school. While anecdotal information on parent change is noted by family literacy staff, little empirical information exists that documents changes in parental involvement over time.

The data in this presentation are part of the Carolina Family Literacy Studies (CFLS), a component of the National Center for Early Development and Learning housed at the University of North Carolina at Chapel Hill. The CFLS Project examines existing family literacy programs in the state of North Carolina, focusing on programs that have the following four components: (a) early childhood education, (b) adult basic education, (c) parenting education, and (d) a designated parent-child time together (PACT). The first cohort of approximately 60 families are from three family literacy programs in the state of North Carolina. All three programs operate an all-day early childhood component 4–5 days a week. A concurrent and co-located intensive adult education program is provided in collaboration with the local community college.

This poster presented findings from the first CFLS cohort on the Parent Observation Record (POR; Adult Learning Source, 1996), a measure developed to rate parent participation in family literacy programs. This rating scale is completed by the staff on each parent twice a year, once after approximately a month of participation and again at the end of the school year. The family literacy staff at the three CFLS sites rated each of the parents in the following areas: involvement in adult education, involvement in the children's program, involvement in family time interaction, child behavior management, and parenting skills. An analysis of pre- and poststaff ratings of parent participation from each of the sites was presented. The data from this measure was related further to parenting information collected during parent interviews.

Given the strong beliefs that family literacy programs have the ingredients to make a difference in the lives of families from low-literacy environments, carefully documented studies are needed to inform practice and policy. A critical area of needed information about family literacy programs is whether or not there are changes in parent attitudes and behavior across the program components and how these changes relate to other parenting variables. Knowledge of such information is essential to practitioners and policy makers in family literacy.

Reference

Adult Learning Source. (1996). *Parent Observation Record.* (Available from the author, 3607 Martin Luther King Boulevard, Denver, CO 80205).

Family-Literacy Programs: A Longitudinal Study of Child, Parent, Family, and Program Variables

Wendy K. K. Lam, Barbara H. Wasik, Dionne R. Dobbins

PRESENTERS: Dionne R. Dobbins, Wendy K. K. Lam

Family literacy programs include a range of interventions that focus on children, their parents, or a combination of the two. Within this larger set of family literacy programs are intergenerational programs, illustrated by the federal Even Start family literacy programs that focus on enhancing the literacy skills of both children and their parents. They include service components in early childhood, adult literacy, parenting education, and parent-child interactions. Underlying these programs is the belief that interventions must focus on the literacy needs of both children and parents to have a lasting effect on the child.

The few evaluations of family literacy programs that have been conducted provide mixed results. Positive child and parent outcomes have been noted, as well as positive relationships between intensity and quality with program outcomes (St. Pierre & Layzer, 1995). Some of these gains, however, appear to be short term and many complex issues have not yet been addressed.

In this presentation, we reported on initial efforts of the Carolina Family Literacy Studies. This project is a component of the National Center for Early Development and Learning, funded by OERI to the Frank Porter Graham Child Development Center of the University of North Carolina. The project includes three major studies. First is a family-focused study that addresses child, parent, family, and program variables. The second involves case studies of selected families. Third is a study of family literacy programs that focuses on issues such as retention, integration, and coordination.

Data collection efforts for the family-focused study were initiated in fall, 1997, in three Even Start family literacy programs in North Carolina. These programs have met the requirement of having all four components of comprehensive family literacy programs and all offer intensive services according to the following guidelines: (a) the program has been in operation for at least 1 year, (b) the program offers a minimum of 15 hours for children and 10 hours for adults per week, and (c) the program designates a specific time for parents and children together. All three programs serve families from different ethnic groups, with total populations served across the three sites being approximately one third Latino, one third African American, and one third European American.

A combination of standardized measures, qualitative interviews, and newly developed instruments designed specifically for family literacy programs have been used. The longitudinal design has allowed for multiple measures of children, parents, teachers, and classrooms, as well as program characteristics and processes throughout the year. Children's measures have focused on emergent literacy skills, behavioral competence, and relationships with teachers and parents. Parent attitudes and behaviors have been assessed through measures that assess their progress and participation in the program, psychosocial functioning, and home literacy environments.

In this presentation, we reported on preliminary data collected over the first year of evaluation, including a description of child and parent variables in the fall and spring and gains made over the year. Further information was presented on new measures of emergent literacy related to the child and classroom.

Reference

St. Pierre, R. G., & Swartz, J. P. (1995). The Even Start family literacy program. In I. E. Sigel (Series Ed.) & S. Smith (Vol. Ed.), *Advances in applied developmental psychology: Vol. 9. Two generation programs for families in poverty: A new intervention strategy* (pp. 37-66). Norwood, NJ: Ablex Publishing Corp.

Voices of Love, Freedom, and Hope

Shelley L. Smith

PRESENTERS: Shelley L. Smith, Dena P. Swanson

The Voices of Love, Freedom, and Hope (VLF&H), an emotions and positive self-concept promotion intervention for at-risk parents and their young children, is designed to function as an emotions literacy curriculum for implementation in family preservation programs. The VLF&H facilitator's guide provides the supporting theory, pedagogy, goals, and structure for the successful implementation of VLF&H in therapeutic parenting education programs. The primary objective of this curriculum is the cultivation and reinforcement of the nurturing and protective skills that parents need to internalize to provide consistent quality self-care and care for their children.

The Voices of Love, Freedom, and Hope was developed as an extension of Voices of Love and Freedom (VLF), a K-12 multicultural literature, ethics, and prevention program and school-based intervention, created by Patrick Walker and developed by the staff of Boston-based Family, Friends, and Community. As with VLF, the constituent components of the VLF&H curriculum, voice, love, freedom and hope, are based in Freirean concepts of dialogue and freedom (Freire, 1993) and are regarded as essential to interpersonal consciousness and relationship building. Using literature as its vehicle, VLF&H employs a unique pedagogy that forms the core of the Voices of Love and Freedom. This method of instruction employs four developmentally and age-appropriate steps ("to connect," "to discuss," "to express," and "to practice") to encourage the scaffolding of interpersonal awareness and skills in children and adults. To meet the literacy and emotional skills levels of at-risk parents and their preschool age children, VLF&H utilizes well-illustrated picture books that portray specific emotions. In parent-to-parent pairs, the books function as catalysts for the discussion of the feelings illustrated in the story and in the past or present lives of the parents. In the parent-child pairs, this process functions as both a bonding agent and literacy enhancement.

Like VLF, Social Perspective Taking (Selman, 1980), a psychosocial/social-cognitive developmental theory functions as the theoretical foundation and operational framework for VLF&H. The Voices of Love, Freedom, and Hope, therefore, is focused on the developmental process of acquiring interpersonal awareness for self and others, and on the ability to know, express, and manage one's own feelings and develop empathy for others. The use of emotion-themed picture books serves as a medium for unlocking the often arrested interpersonal skills and consciousness that characterize many parents participating in family preservation programs. As a prevention, VLF&H plays a pivotal role in the development of empathy in the preschool-age child of parents whose physical and/or emotional abuse or neglect of the child places him or her at risk for the same behaviors. In concert, the twin components comprising the VLF&H curriculum seek to promote an internalized understanding of the feeling states of the self, other, and self in relationship to other, thereby strengthening parenting skills and unifying families. The Voices of Love, Freedom, and Hope seeks to reignite a sense of hope in the at-risk parent that allows one to look towards the future and envision who she might be, how she might change her environment, and what she can do for those she loves (Walker, 1993).

References

Freire, P. (1993). *Pedagogy of the oppressed.* New York: The Continuum Publishing Company.

Selman, R. L. (1980). *The growth of interpersonal understanding: Developmental and clinical analyses.* San Diego, CA: Academic Press, Inc.

Walker, P. (1993). Acknowledgements and Introduction (Teacher Training Modules). In *Voices of Love and Freedom: A K–12 multicultural ethics and literacy program* (pp. 3–38). Jamaica Plain, MA: Family, Friends and Community.

Local Knowledge: Exploring Family Involvement in Head Start

Mary deVries, Sally Lubeck

PRESENTER: Mary deVries, Sally Lubeck

The Head Start Performance Standards provide the framework for the provision of opportunities for family involvement in all Head Start programs. Yet, this study found that the actual nature of family involvement opportunities was distinct in each of three Head Start programs. Staff expectations of parents, staff perceptions of parents, staff and family relationships, and the beliefs of how programs might best serve families was understood very differently in these three communities. In this ethnographic-style study, time was spent volunteering in classrooms, participating in various family activities, and talking with staff, teachers, and parents. Data included historical and demographic materials, field notes, and interview transcripts.

The first center we worked in was located in a working-class industrial community of mixed African American and European American background. Teachers and staff members did not seem to share a broad overriding philosophy for themselves as a group. Nonetheless, program personnel were fully committed to assisting all of the many grandmothers who were raising grandchildren as primary caretakers. Children of these grandmothers were given priority in enrollment. In the spirit of family support, the parent coordinator and social worker focused much of their energies on providing a support group and needed services for these grandmothers.

The second Head Start site was almost entirely European American, rural, and located in a high-income community. Following the traditional values of this community, family involvement was often construed as parent education. Parenting classes were regularly scheduled by the parent coordinator and regularly attended by a group of mothers. Head Start staff members often saw themselves as role models for the mothers, giving examples from their own lives of interactions with their own children. The spirit of family involvement as parent education ran clearly through many of the interactions with parents.

The third Head Start site met the challenges of this African American, urban, and extremely low-income community enthusiastically. The parent coordinator described the families in this program as strong families with a strong sense of family values that came from their past as a people. Parents here were encouraged to take an active part in their community. Social action was the rallying cry of this community.

The fourth Head Start site, located in a midsized, urban community, served a population of tremendous cultural and linguistic diversity. Staff members told us, "the old ways of doing things just don't work." Workshops were a thing of the past. The family coordinator did not see her role as that of presenting information on parenting, but as one of building relationships with families and the community. Family assessment included the description of dreams for the family, rather than goals. This seemed to better capture the affirmation that Head Start had for each distinct family, rather than imposing intervention on the distinct nature of family life that was present in this community. At the heart of the many family success stories of this Head Start site lay a foundation of close staff and family relationships.

Socioeconomic Class Differences in Parents' Beliefs Regarding Parent-Child Reading

Deborah E. Carroll, Marie Fholer, Lisa Reece

PRESENTER: Deborah E. Carroll

Seventy-six parents of 3- to 6-year-old children, representing working-class (38.2%), middle-class (28.9%), and upper middle-class (32.9%) families, were recruited. These parents were surveyed regarding their beliefs about their influence on their young children's cognitive development and their beliefs and strategies regarding parent-child reading. The purpose of the study was to examine socioeconomic class differences in parents' beliefs. Results indicated that working-, middle-, and upper middle-class parents believe themselves to be important to their young children's cognitive development ($F(2, 73) = 1.363$, $p > .05$). Parents did vary in their beliefs about reading with their young children by socioeconomic class ($F(2, 73) = 6.922$, $p < .01$). Upper middle-class parents were more likely than working-class parents to say they believed parent-child reading should be a time for learning, social interaction, and child-directed reading ($t(52) = 3.71$, $p < .01$). Middle-class parents also were more likely than working-class parents to indicate these beliefs ($t(49) = 2.15$, $p < .05$). No significant differences were found among upper middle-class parents and middle-class parents ($t(45) = 1.29$, $p > .05$). When age of child was entered as a covariate, socioeconomic class showed no significant effects on how often parents reported reading with their children ($F(2, 71) = 2.673$, $p > .05$) or how long they read ($F(2, 71) = 1.791$, $p > .05$). Parents varied in the strategies they reported using with their children by socioeconomic class ($F(2, 71) = 4.133$, $p < .05$). Upper middle-class parents were more likely to use reading strategies with their children which utilized inflection, character-acting, and story-telling than were middle-class parents ($t(44) = 2.12$, $p < .05$) or working-class parents ($t(51) = 3.11$, $p < .01$). There were no significant differences among parents of middle-class and working- class socioeconomic status ($t(47) = .52$, $p > .05$). In changing or not changing strategies as children make the transition to schooling, working-class parents were slightly more likely than middle- and upper middle-class parents to say they would continue reading just as they have been ($F(2, 30) = 3.145$, $p = .058$). Parents were asked why they answered as they did. Upper middle-class parents were more likely than working-class parents to give child-centered reasons ($t(28) = 2.02$, $p = .05$). Middle-class parents were also more likely than working-class parents to give child-centered reasons ($t(25) = 2.82$, $p < .01$). No significant differences were found between upper middle-class and middle-class parents ($t(31) = .86$, $p > .05$). Teachers in Head Start programs may provide parent education which includes strategies for parent-child reading. Indicators are present which show that the strategies parents use may differ by socioeconomic class. The findings that parents from working-class backgrounds place less emphasis on reading as a time for learning and social interaction and see less of a need to adjust their interactions at school entry may have important implications for parent education programs.

Grandparent-Caregiver Legal Services Project of the Family Advocacy Program: A Tier Three Program Evaluation

Laura Williams Gal, Margaret Vaughan

PRESENTERS: Laura Williams Gal, Margaret Vaughan

The paper documents the process and findings of a 2-year action, research, and evaluation project conducted by the Family Advocacy Program (FAP) of Boston Medical Center (BMC) on children being raised in kinship care. The particular form of evaluation, a "tier three" evaluation, takes place during the life of a project and seeks to assist programs in clarifying, assessing, and adjusting goals as a project develops. This evaluation was conducted 1 year after the creation of the Grandfamilies Legal Services Project (GFLSP). The author met extensively with the project manager to review the project's history and development, services provided to date, and future plans. Interviews were also conducted with individual clients and group leaders with whom the project worked.

Boston Medical Center added a legal services program, the FAP, to its Pediatrics Department in order to address some of the social/environmental issues that exacerbate or cause many of the health problems suffered by the hospital's pediatric patients. The FAP is one of the first in the country. Providing legal services as part of a comprehensive health care package for children and their families sheds light on several trends. One trend was the growing number of children being cared for by a grandparent. The FAP learned of this trend because of the many legal obstacles grandparents face when trying to procure financial assistance, benefits, and services for their grandchildren.

In response, the GFLSP was created.

At the time of its evaluation, the GFLSP provided education, consultation, and representation to Boston-area grandparents raising their grandchildren. Approximately 30 predominantly minority grandmothers used the project at any given time. Several urban and suburban organizations also received educational outreach and consultation. At the 1-year mark, approximately 80 grandparents had received individual legal services, many for multiple issues. Eighty-five percent were caring for more than one grandchild. Among the goals of the project were income and benefits maintenance and maximization, improved relationship with and support from the Massachusetts Department of Social Services, education of client groups and area health care professionals on legal issues affecting grandparent-headed families, and preservation of grandparent-headed families.

The purpose of the evaluation was to provide consultation and planning assistance. Specific questions addressed were: (a) to what extent was the project providing services as intended and (b) should services be modified/are community needs being met. Information gathering involved a literature review and interviews with both the project manager and clients. Interviews with grandparent support group leaders were based on a questionnaire developed through collaboration between the author and the project manager, which focused on statistic gathering, prioritizing services desired, and critiquing the project.

The GFLSP did not have any built-in evaluation mechanism, so the tier three approach was appropriate and useful. Many of the project's goals were being met, but in ways unanticipated at the project's inception (e.g., client groups placed highest priority on outreach and consultation). Limited funding made this information critical to future planning.

What Do Parents Want and Expect From Head Start: A Comparison of European American and Puerto Rican Parents' Beliefs and Expectations About Socialization and Learning in Head Start

Beena Achhpal, Jane Goldman

PRESENTERS: Beena Achhpal, Jane Goldman

Cross-national studies have identified intercultural differences in parents' belief systems about child-rearing and socialization. However, within the U.S., research concerning the beliefs of ethnic minority parents whose children are involved in early intervention programs is limited. To begin to meet the need for such information, this study was designed to identify and compare the socialization goals and the expectations of European American and Puerto Rican parents of Head Start children.

Participants in the study were 60 parents (55 mothers, 4 grandmothers, and 1 father) of children in Head Start programs in Northeast Connecticut. Thirty parents were of European American background, and 30 parents were Puerto Rican. The parents were interviewed using a semistructured interview schedule developed for the study.

The first part of the interview covered demographic information. Overall, the European American and Puerto Rican samples were similar. Ages ranged from 20 to 45 years of age. Fifty-five percent were single parents. Twenty-nine were employed in semiskilled jobs and 31 were not employed.

In the second part of the interview, the parents were asked about the competencies and skills they valued for their preschool children. The parents were asked to rank eight major developmental domains in terms of how important they believed those skills were for their children. Both the Puerto Rican and European American mothers identified emotional-affective development and social skills with adults as most important. However, while the Puerto Rican parents placed more emphasis on social skills with adults, the European American parents placed more emphasis on emotional-affective skills. European American mothers also placed more importance on autonomy than Puerto Rican mothers. In contrast, the Puerto Rican mothers placed more emphasis on preacademic skills. There were no significant differences between the groups in their rankings of social skills with children and self-help skills; both were of moderate importance. Both groups put the least importance on development of physical and creative skills.

While part two gave information on the parents' overall goals for their children, the third part was designed to identify which of these domains the parents believed should be emphasized in their child's Head Start program. Here, also, the Puerto Rican mothers placed more importance on the teaching of social skills with adults and on preacademic skills. The European Americans mothers placed more emphasis on autonomy.

There is considerable literature emphasizing: (a) the importance of working with families, (b) the importance of considering cultural values and expectations of families from different ethnic backgrounds, and (c) development of need-based early education programs, interventions, and curriculums. The results of this study provide a model for linking these three areas. Such information can help Head Start personnel, administrators, and policy makers to understand the educational needs and expectations of parents and communities for planning, implementing, and enhancing need-based intervention programs and services.

Agreement of Head Start Parents and Teachers on Developmental Goals for Children

Susan L. Churchill

PRESENTER: Susan L. Churchill

This study examined the endorsement of developmental goals of Head Start teachers and parents in three different Head Start centers. Parent involvement in Head Start was predicted using an agreement index based on the endorsement of goals. The agreement index for developmental goals was positively associated with parent involvement as reported by the teacher and the parent. Specifically, the agreement index was positively associated with the total involvement score and the assistance subscale.

The total involvement score is a sum across parent involvement items representing the parents' involvement in Head Start across a number of dimensions. The higher this score, as reported by the teacher, the higher the agreement index. This measurement of agreement between the teacher and parent on goals accounted for an additional 8% of the variance in total involvement above that accounted for by differences in the Head Start centers.

The assistance subscale measured activities that the parent was involved in at the center or in the classroom, such as helping in the classroom or on field trips. The higher the agreement between teacher and parent on the ranking of goals for children, the more assistance the parent gave to the teacher (as reported by the teacher). The agreement between these two views accounted for 9% of the variance in Head Start parent involvement above that accounted for by differences in Head Start centers.

When parents and teachers endorse similar goals for children in their care, parents are more involved in the Head Start program. This effect was found even when controlling for demographic similarities and differences among Head Start centers in parent involvement. It is suggested that congruent goals reflect parents' and teachers' similar "world views" about parenting and schooling children.

Linkages Between Children's Narrative Representations of Families and Social Competence in Child Care Settings

Timothy Page, Inge Bretherton

PRESENTER: Timothy Page

Bowlby's term "internal working model" (Bowlby, 1982) refers to the ways in which children organize stored memories of experience with their caregivers. Internal working models become, essentially, sets of social expectations which the child transports across various social relationships. A child who has developed expectations of helpfulness and cooperation in relationships, and of his or her own worth in relation to others, will have an advantage in the formation of social relationships outside the home.

One important focus of recent attachment research with preschool-aged children has been the creation of measures that access children's internal representations of their interpersonal worlds. This study, which was part of a larger study funded by the National Institute of Mental Health (Bretherton, 1991), examined associations between preschool children's internal working models of family relationships as represented in their narrative responses on a laboratory task and the quality of their social behavior with peers and child care providers in child care settings as rated by providers. Concurrent associations between these two variable domains

provides evidence for the role played by internal working models in "developmental continuity" across social contexts (Sroufe & Fleeson, 1986). For the first time, the question of how preschool-aged children organize experience into internal working models was examined in a sample of children of divorced parents.

Children's internal working models of family relationships were assessed using a revised version of the Attachment Story Completion Task (Bretherton, Prentiss, & Ridgeway, 1990). Social competence in child care settings with peers and child care providers was assessed with three instruments corresponding to three dimensions of social behavior. Sixty-six children (39 boys, average age 56 months) living primarily in the custody of their mothers participated. The families were mainly White and middle class. Contact took place at least 2 years after the parents' divorce. A one-sample, correlational design was used, reflecting the study's focus on within-group comparisons. The data were analyzed using hierarchical multiple regression.

Several associations were found between narrative representations of the father and mother figures and children's social competence. Socially competent children tended to create narrative depictions of: (a) the father's involvement in an array of parental roles in the child protagonist's life; (b) children's close relationships with the mother; and (c) expressions of clear boundaries and order between the households of mother and father.

Gender differences were also found. Boys who created few positive representations of parents, especially with the father figure, tended to be described as aggressive, uncooperative, or hyperactive. Girls in this category tended to exhibit social behavior characterized as overly responsible to peers.

Actual family interactions, similar to those found here in children's narratives, have been linked to children's social competence in the divorce literature (Hetherington, Cox, & Cox, 1982; Wallerstein, 1984; Emery, 1988), but these linkages have never before been reported for children's narrative representations of postdivorce family relationships. This narrative method, therefore, appears to be useful for understanding children's perceptions of family relationships, holding promise for applications in both research and practice.

References

Bowlby, J. (1982). *Attachment and loss, Vol. I: Attachment* (2nd ed.). New York: Basic Books.

Bretherton, I. (1991). Attachment organization in single-parent families. Unpublished research proposal.

Bretherton, I., Prentiss, C., & Ridgeway, D. (1990). Family relationships as represented in a story-completion task at 37 and 54 months of age. In I. Bretherton & M. E. Watson (Eds.), *Children's perspectives on the family: New directions for child development: No. 48* (pp. 85–105). San Francisco: Jossey-Bass.

Emery, R. E. (1988). Marriage, divorce and children's adjustment. *Developmental clinical psychology and psychiatry: No. 14*. Newbury Park, CA: Sage.

Hetherington, E. M., Cox, M., & Cox, R. (1982). Effects of divorce on parents and children. In M. E. Lamb (Ed.), *Nontraditional families: Parenting and child development*. Hillsdale, NJ: Lawrence Erlbaum.

Sroufe, L. A., & Fleeson, J. (1986). Attachment and the construction of relationships. In W. Hartup & Z. Rubin (Eds.), *Relationships and development* (pp. 51–71). Hillsdale, NJ: Lawrence Erlbaum.

Wallerstein, J. S. (1984). Children of divorce: The psychological tasks of the child. *Annual Progress in Child Psychiatry and Child Development*, 263–280.

Parenting Goals in an Inner-City, African American Community: Developing a Framework for Intervention

Karen Freel, Linda Gilkerson, Theresa Hawley, Frances Stott

PRESENTER: Karen Freel

During the past 2 decades, there has been a growing awareness that effective intervention with parents of infants and young children requires an understanding of and respect for cultural differences and community norms for childrearing. However, intervention programs and instruments for assessing parent progress are frequently based on academically derived principles of what constitutes "good parenting," and may not reflect the parenting goals, beliefs, and practices that are most prevalent in the community being served.

The authors convened a multisession focus group, called a "caregiving consensus group," to gain insight from mothers who participate in an Early Head Start (EHS) program in an inner-city, African American community about what they believe constitutes good parenting. Results of the research will inform the development of a new approach to intervention and to the measurement of participant progress. This poster focused on information gained through this group.

A participatory action research framework allowed EHS staff and community residents numerous opportunities to give input into the project design, data collection, and analysis procedures. A project advisory board consisted of the four principal investigators, seven EHS staff members, and three EHS parents.

Four central questions guided the project: (a) What does it mean to be a good parent in the community? (b) What are the supports and stresses in parents' lives? (c) What do parents want for their children and how do they help them reach the goals that they believe are important? and (d) How can EHS help?

Eight mothers, ranging in age from 15 to 33 years old (Mean age = 22) comprised the caregiving consensus group. Participants were recruited by EHS staff and other group members and were paid $20 for each session they attended. Each meeting was co-led by two of the authors and by a parent from the community. Discussion topics, spread over six 90-minute sessions, included: caregiving routines, discipline, supporting children's development, abuse and neglect, the role of fathers in children's lives, and parents' (and grandparents') goals for their children. With parent consent, meetings were audiotaped and the tapes transcribed verbatim.

The authors reviewed the transcriptions, identified significant themes, and wrote an initial draft of the results. The advisory board, the caregiving consensus group, and EHS staff provided feedback on the report which was incorporated into subsequent drafts. Themes from the discussions included: (a) the special bond between mother and child, (b) the primary responsibility mothers hold for childrearing, (c) the mothers' desire to develop more effective discipline strategies and patience, and (d) their hope of helping their children realize a better life.

The research identified the importance of predictable and trustworthy relationships between staff and participants and of establishing the program as a safe haven in an often harsh community environment. Staff face the challenge of supporting both the mothers' immediate parenting goals, including basic survival, protection, and independence in their children, and their longer-term goals, for example, helping their children succeed in school. In general, the mothers found the sessions very engaging, suggesting possible benefits of incorporating small group work into EHS program options.

Factors Affecting the Relationship Between Parenting and Achievement: The Role of Ethnicity, Grade Level, and Gender of the Child

Judith McCullough, Christia Johnson, Laura Diaz

PRESENTER: Judith McCullough

Research has shown that both positive parenting and academic achievement are protective factors for children at highest risk for a host of mental disorders and maladaptive outcomes in later life, including juvenile delinquency, depression, low self-esteem, welfare dependency, and unemployment (Schweinhart, Barnes & Weikart, 1992; Yoshikawa, 1994). Furthermore, successful interventions often target positive parenting and academic achievement as means to protect children of poverty from maladaptive trajectories (e.g., Head Start, Carolina Abecedarian Project—see Yoshikawa, 1994, for a review).

The purpose of the current study was to assess the significance of the relationship between academic achievement and positive parenting in a predominantly ethnic minority sample (N = 49) of Head Start graduates. Families of high achievers were compared to families of low to average achievers on aggregated general parenting styles (authoritative, authoritarian, permissive), component general parenting style behaviors (warmth/acceptance, psychological control, lax discipline), and education-specific parenting practices (parent involvement in school, cognitive home environment). A second goal was to better understand how the relationship between achievement and different types of parenting was moderated by ethnicity, grade level, and gender of the children in the study.

Specifically, we hypothesized that while authoritative parenting as an aggregate parenting style may distinguish Latino high achievers from Latino average achievers, it will not distinguish African American high achievers from African American average achievers. However, both Latino and African American high achievers will demonstrate higher levels of two aspects of authoritative parenting: acceptance and psychological autonomy granting. In addition, families of high achievers from both ethnic groups will exhibit higher levels of education-specific parenting practices. It is also expected that ratings of parental acceptance and psychological autonomy granting will be related to psychological constructs associated with academic achievement: perceived scholastic competence, global self-esteem, and behavioral conduct.

Given the increased developmental demands for autonomy, older children will require greater amounts of psychological autonomy granting and lower levels of education-specific parenting practices from parents in order to achieve. Negative parenting practices will have a greater effect on female academic achievement than on male academic achievement.

References

Schweinhart, L., Barnes, H., & Weikart, D. (1993). Significant benefits: The High/Scope Perry Preschool Study through age 27. *Monographs of the High/Scope Educational Research Foundation, 10.* Ypsilanti, MI: High/Scope Press.

Yoshikawa, H. (1994). Prevention as cumulative protection: Effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin, 115*(1), 28–54.

Predicting Parent Involvement and Its Influence on School Success: A Follow-Up Study

Rebecca A. Marcon

PRESENTER: Rebecca A. Marcon

Parent involvement is important for children's school success. Zill (1996) found higher levels of parent involvement to be associated with better student outcomes on nearly all achievement and behavior measures. Parent involvement enhances academic and social performance of low-income children at the end of Head Start (Taylor & Machida, 1994), first grade (Reynolds, 1989), and third grade (Marcon, 1993). The positive impact is especially strong in grades 3 through 5 (Crimm, 1993). In high-risk neighborhoods, parent involvement seems especially important during the transition from elementary to middle school (Eccles & Harold, 1993) and plays a vital role in denoting which children remain academically at risk or improve academically across the transition (Vito, 1993).

The present study provided follow-up data on 122 inner-city children enrolled in 91 public schools in Washington, D.C. Demographic and school-related predictors of involvement were examined as children made the transition from elementary to junior high school. Involvement categories included parent-teacher conference, home visit by teacher, extended class visit by parent, and parental help with class activity. Two groups were identified based upon low (0 or 1 category fulfilled) or high (3 or 4 categories fulfilled) involvement. A covariate controlled for economic differences.

Parents whose children had attended Head Start were significantly more involved than were parents whose children had attended pre-k. No differences in current involvement were found between single- and two-parent families, and parents of boys were as likely as parents of girls to be involved. While previous levels of involvement were not predictive of current levels, parents whose children had attended a child-initiated preschool tended to be more involved.

Variance in current parent involvement was best predicted by income (higher), followed by child's age (younger), participation in Head Start, and successfully passing the primary grades. Discriminant analysis successfully classified 73% of the parents into either low or high categories of involvement. Type of preschool program alone (Head Start vs. pre-k) correctly classified 69% of the sample.

Children whose parents had been uninvolved in first grade were significantly more likely to receive special education. Children whose parents had been uninvolved in kindergarten, first, or third grade were significantly more likely to be retained before junior high. High current involvement was associated with significantly higher grade point averages and higher grades in 8 of 11 subjects. Children whose parents had been highly involved in third grade scored higher in all sixth grade Comprehensive Test of Basic Skills (CTBS) areas.

Head Start continues to have a positive impact on parent involvement as children enter junior high school. Current involvement was associated with higher grades, while past involvement had a positive impact on achievement test scores and school competence. Although lower family income was generally predictive of lower involvement, this was not the case for Head Start families. DC Head Start's emphasis on parental empowerment and child-initiated early education had an enduring impact on families. Seven and 8 years after their children have left Head Start, parents in our nation's capital remain involved in their children's educational experiences and the effect is notably positive.

References

Crimm, J. (1993). Parent involvement and academic achievement: A meta-analysis. *Dissertation Abstracts International, 53*(07), 2169A.

Eccles, J. S., & Harold, R. D. (1993). Parent-school involvement during the early adolescent years. *Teachers College Record, 94*, 568–587.
Marcon, R. (1993). Predictors of parent involvement and its influence on school success [abstract]. *Proceedings of the National Head Start Research Conference: Vol 2* (p. 380). Washington, DC: ACYF.
Reynolds, A. J. (1989). A structural model of first-grade outcomes for an urban, low socioeconomic status, minority population. *Journal of Educational Psychology, 81*, 594–603.
Taylor, A. R., & Machida, S. (1994). The contribution of parent and peer support to Head Start children's early school adjustment. *Early Childhood Research Quarterly, 9*, 387–405.
Vito, R. C. (1993). Why students become "at-risk". *Dissertation Abstracts International, 54* (04), 1298A.
Zill, N. (1996). Family change and student achievement: What we have learned, what it means for schools. In A. Booth & J. F. Dunn (Eds.), *Family-school links: How do they affect educational outcomes?* (pp. 139–174). Mahwah, NJ: Erlbaum.

Predictors of Parenting Stress Among First-Time, Low-Income Mothers

Kathy Thornburg, Jean Ispa, Mark Fine, Elizabeth Sharp, Miriam Wolfenstein, Michelle Mathews, Donna Koller

PRESENTERS: Kathy Thornburg, Jean Ispa, Mark Fine, Elizabeth Sharp, Miriam Wolfenstein, Michelle Mathews, Donna Koller

Parenting stress—the amount of stress experienced by a parent in his or her parenting role—has been identified as an important contributor to a wide variety of parent and child outcomes. However, we know relatively little about both the concurrent and longitudinal predictors of later parenting stress among low-income, first-time mothers who constitute an at-risk group by nature of their limited financial resources and lack of parenting experiences. In this study, we examined concurrent and longitudinal predictors of parenting stress among a sample of mothers in the Early Head Start program. Specifically, we assessed a variety of variables when the mothers entered the program (intake), several variables when their children were either 6 or 12 months old (Time 2), and two key dimensions of parenting stress at Time 2.

Participants were 128 first-time mothers who were enrolled (either as a member of the program or comparison group) in the KCMC Early Head Start program in Kansas City, Missouri. As part of the intake procedure, participants were administered a series of psychometrically established measures of constructs thought to influence parenting stress (i.e., maternal characteristics; child characteristics; and stressful life circumstances, such as coping styles, depression, parenting mastery, literacy, and knowledge of child development). When the child was either 6 or 12 months old (Time 2), the mother was again administered a battery of instruments, including two scales of Abidin's Parenting Stress Index - Short Form (1990), Parental Distress and Parent-Child Dysfunctional Interaction, and the following concurrent predictors of parenting stress: (a) infant attachment, (b) relationship satisfaction, as measured by the Dyadic Attachment Scale, (c) family conflict (from the Family Environment Scale), (d) home environment, as measured by the Infant/Toddler HOME Inventory, (e) infant temperament, as measured by the Infant Behavior Questionnaire, and (f) maternal temperament, as measured by the Multidimensional Personality Questionnaire, Form NZ.

Pearson correlations were computed between the measures of the predictor variables (both those administered at intake and those administered at Time 2). With respect to longitudinal predictors, high levels of avoidance and low levels of active planning as coping mechanisms were associated with more parenting distress and less parent-child dysfunctional interaction. High levels of mastery, literacy, and low levels of depression were also linked to less parenting stress at Time 2.

In terms of concurrent predictors, mothers who reported having more securely attached infants, greater relationship satisfaction, and less family conflict reported less dysfunction in interactions with their infants and less parenting distress. In addition, dysfunctional parent-child interactions were related in the expected direction to several subscales of the Infant/Toddler HOME Inventory: less parenting distress and parent-child interactional dysfunction was related to more acceptance, organization, learning materials, and variety in the home environment. In addition, parenting stress was generally related to more dysfunctional maternal personality characteristics and more difficult infant temperaments.

Reference

Abidin, R. R. (1990). *Parenting Stress Index/Short Form.* Charlottesville, VA: Pediatric Psychology Press.

Work Family Role Strain and Parenting Style

Arminta L. Jacobson, Kimber Lucas

PRESENTER: Arminta L. Jacobson

As more low-income mothers of infants and toddlers leave welfare for work, issues related to role strain and parenting evolve. Crockenberg (1988) found that low-income, single mothers tend to work out of necessity and have less social support than mothers with higher incomes. This may be due to the mothers' inability to buy services that can help deal with the time conflicts of work and family. Because these mothers tend to have less control over their work schedule, there is little or no child care available. Shipley and Coats (1992) found these low-income single mothers to be less action-oriented in their coping skills and to have lower self-esteem, and, thus, to have greater role strain.

Work-family role strain is an issue that is common to all working mothers of young children. Mothers with children under 3 years of age have been found to be more likely to have greater role strain than mothers with older children (Higgins, Duxbury, & Lee, 1994). Crouter (1984) found women with younger children to be at risk for perceiving the impacts of work-family role strain.

Role strain has been found to affect mother-child interaction (Beyer, 1995; O'Neil & Greenberger, 1994). Mothers with high work-family role strain set more limits on their children (Lerner & Galambos, 1988). The importance of mother-child interaction to early child development is well known. Nurturance and control, parenting-style features that are evident from early parenting, are two interactional factors that have been found to affect child development. Parenting with a high level of arbitrary control and low nurturance is prone to create behavioral and psychological problems (Dodge, Pettit, & Bates, 1994; McLoyd, Jayaratne, Ceballo, & Borquez, 1994). Authoritative parents, high in nurturance and rationale control, have children high in cognitive and social skills (Baumrind, 1967, 1971, 1980).

A survey was completed by 45 economically, educationally, and culturally diverse mothers of children under 3 years of age. The children were enrolled in eight nonprofit early childhood centers in a Southwest metropolitan area. Seventy-three percent were members of two-parent families with both parents working outside the home. The mothers had an average of 1.64 children. Mothers were asked to state their level of agreement with views expressed in statements related to work and family interrole conflict (Kopelman, Greenhaus, & Connolly, 1983). The mean score on the scale was 20.64 (range from 8.00 to 36.00) with a possible score of 40.00. Open-ended questions provided qualitative information about mothers' perceived work-family

role strain. The majority found working and having children difficult. Mothers emphasized prioritizing family, the importance of support, and quality child care. Employment benefits such as flextime, job sharing, and a good employer were helpful.

The Parental Authority Questionnaire (PAQ; Buri, Louiselle, Misukanis, & Mueller, 1988) was used to measure mothers' perceptions of their parenting styles, defined by Baumrind's (1971) authoritarian, permissive, and authoritative parental prototypes. With a possible range of 1.00 to 5.00, the mean for permissive parenting style was 2.24, authoritarian parenting style 2.75, and authoritative parenting style 4.20. There was no correlation between parenting styles and role strain. There was a positive correlation between number of children and authoritative parenting style. It could be assumed that the work-family balance would be more challenged as the number of children increased. The relationship between work-family role strain and parenting style may be more evident in families with more children. Research has shown that nonemployed mothers have been found to use more control strategies with their children, while working mothers displayed more guidance and responsiveness toward their children. These parents, especially the mothers who worked longer hours, may avoid confrontation with their children to compensate for their absence (Beyer, 1995; Crockenberg & Litman, 1991). Research has shown that mothers from low-income families tend to have low levels of nurturance (Lee, 1994). Low-income working mothers with strained resources may need support and guidance in maintaining positive nurturing involvement with their children.

Although the research sample was small, there was confirmation of the work-family role strain experienced by working mothers of infants and toddlers. While mothers may experience role strain, there is no evidence that a particular pattern of parenting style is associated with this role strain. It cannot be construed that the pressures of a working mother will lead toward more punitive authoritarian parenting. Parent education may address work and family balance as a way of helping families prioritize and have more time and energy for parenting. Head Start and other early childhood settings can strive to be "family friendly" in ways that reduce role strain. Increased flexibility of scheduling, parent support groups, and improving the quality of care—ways that parents find helpful in reducing role strain—are worthwhile goals.

References

Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs, 75* (1), 43–88.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monographs, 4*(1, Pt. 2) 1–103.

Baumrind, D. (1980). New directions in socialization research. *American Psychologist, 35*(7), 639–652.

Beyer, S. (1995). Maternal employment and children's academic achievement: Parenting styles as mediating variable. *Developmental Review, 15*, 212–253.

Buri, J. R., Louiselle, P. A., Misukanis, T. M., & Mueller, R. A. (1988). Effects of parental authoritarianism and authoritativeness on self-esteem. *Personality and Social Psychology Bulletin, 14*(2), 271–282.

Crockenberg, S. (1988). Stress and role satisfaction experienced by employed and nonemployed mothers with young children. *Lifestyles: Family and Economic Issues, 9*, 97–110.

Crockenberg, S., & Litman, C. (1991). Effects of maternal employment on maternal and 2-year-old child behavior. *Child Development, 62*, 930–953.

Crouter, A. C. (1984). Spillover from family to work: The neglected side of the work-family interface. *Human Relations, 37*(6), 425–442.

Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994). Socialization mediators of the relationship between socioeconomic status and child conduct problems. *Child Development, 65*(2), 649–665.

Higgins, Duxbury, L., & Lee, C. (1994). Impact of life-cycle stage and gender on the ability to balance work and family responsibilities. *Family Relations, 43*, 144–150.

Kopelman, R. E., Greenhaus, J. H., & Connolly, T. F. (1983). A model of work, family, and interrole

conflict: A construct validation study. *Organizational Behavior and Human Performance, 32,* 198–215.
Lee, Y. (1994). *The relationship of Chinese Malaysian maternal child rearing practices and preschool children's empathy.* Unpublished master's thesis, University of North Texas, Denton, Texas.
Lerner, J. V., & Galambos, N. L. (1988). The influence of maternal employment across life: The New York longitudinal study. In A. E. Gottfried & A. W. Gottfried (Eds.), *Maternal employment and children's development* (pp. 59–83). New York: Plenium.
McLoyd, V. C., Jayaratne, T. E., Ceballo, R., & Borquez, J. (1994). Unemployment and work interruption among African American singles mothers: Effects on parenting and adolescent socioemotional functioning. *Child Development, 65*(2) 562–589.
O'Neil, R., & Greenberger, E. (1994). Patterns of commitment to work and parenting: Implications for role strain. *Journal of Marriage and the Family, 56,* 101–112.
Shipley, P., & Coats, M. (1992). A community study of dual-role stress and coping in working mothers. *Work and Stress, 6*(1), 49–63.

Processes by Which Parent Involvement in Head Start Improves the Lives of Families

Susan L. Kessler-Sklar, Amy J. L. Baker, Faith Lamb-Parker,
Chaya S. Piotrkowski, Lenore Peay, Beryl Clark

PRESENTERS: Susan L. Kessler-Sklar, Faith Lamb-Parker

Recent research on parent involvement in Head Start has addressed two major issues which impact on program and policy: (a) What are the positive outcomes of parent involvement for parents, children, and other family members? and (b) What are the best ways to conceptualize and measure parent involvement in order to assess its true impact? With respect to the first issue, the outcomes of parent involvement, several studies have found positive outcomes for parents (e.g., Oyemade, Washington, & Gullo, 1989; Slaughter, Lindsey, Nakagawa, & Kuehne, 1989; Parker, Piotrkowski, & Peay, 1987), Head Start children, and siblings (Seitz & Apfel, 1994; Leik & Chalkley, 1994; Parker, Piotrkowski, Kessler-Sklar, Baker, Clark, & Peay; 1997). The second issue, the conceptualization and measurement of parent involvement, has traditionally been addressed by asking parents retrospectively to rate subjectively the extent of their involvement as low, medium, or high. Early work by Parker, Piotrkowski, and Peay (1987) advanced methodology in this area by conceptualizing parent involvement as all of the naturally occurring activities and services utilized by parents during the Head Start year. Accuracy of the data was improved by measuring the actual participation of parents as recorded on Head Start records. These two issues were further addressed by Parker et al. (1997) in a 5-year research project of the National Council of Jewish Women Center for the Child.

Reported here is a substudy of that project that focuses attention on the second issue, the conceptualization and measurement of parent involvement, and also explores how these conceptualizations might lead to positive parent and child outcomes. Specifically, the present study explores two processes by which involvement may lead to positive outcomes for parents and children: (a) level of initiative required by an activity and (b) the skill gained from participation. Three related questions were addressed: (a) What are the skill and initiative levels of the activities offered to parents? (b) What are parents' patterns of participation? and (c) Can the processes of initiative and skill account for positive outcomes resulting from parents' involvement?

One hundred and seventy-two Dominican American families at a Head Start agency in a large Northeastern city participated in the study. Two expert judges rated the initiative and skill levels of the 22 parent involvement activities offered by the agency. Initiative ratings could range from very low to very high. Skill ratings could range from very simple to very complex. For each

parent, two scores were computed representing the total initiative required and the total skill gained from participation. Results revealed that the range of initiative and skill levels of activities offered to parents was limited, with most falling in the low to moderate range. The very high-level activities consisted only of policy meetings/offices, as opposed to volunteering and workshops, which are available to relatively few parents.

Regression analyses which controlled for demographic factors and pretest revealed several significant relationships between parents' overall initiative and skill scores and positive outcomes for them and their children. For instance, parents who chose activities requiring more initiative and providing more complex skills also helped their child learn significantly more school-readiness skills and volunteered significantly more often in their child's kindergarten classroom. Parents who engaged in activities requiring higher initiative also had children whose performance was significantly more highly rated by their kindergarten teachers. These results were intriguing and suggested avenues for future research, such as refining the concepts of initiative and skill and identifying additional processes which may influence outcomes. Methodological limitations of the data were discussed. Policy and programmatic recommendations to improve the parent involvement component of the Head Start program were offered.

References

Leik, R. K., & Chalkley, M. A. (1994). *The Head Start family impact project.* Final report to Administration on Children, Youth, and Families. Minneapolis, MN: University of Minnesota.

Oyemade, U., Washington, V., & Gullo, D. (1989). The relationship between Head Start parent involvement and economic self-sufficiency of Head Start families. *Journal of Negro Education, 58*(1), 5–15.

Parker, F. L., Piotrkowski, C. S., & Peay, L. (1987). Head Start as a social support for mothers: The psychological benefits of involvement. *American Journal of Orthopsychiatry, 57*(2), 220--233.

Parker, F. L., Piotrkowski, C. S., Kessler-Sklar, S., Baker, A. J. L., Peay, L., & Clark, B. (1996). *The impact of parent involvement in Head Start on parents and children.* Final report to Administration on Children, Youth, and Families (Grant No. 90-CD-0073/3). New York: National Council of Jewish Women.

Seitz, V., & Apfel, N. H. (1994). Parent focused intervention: Diffusion effects on children. *Child Development, 65,* 677–683.

Slaughter, D. T., Lindsey, R.W., Nakagawa, K., & Kuehne, V. S. (1989). Who gets involved? Head Start mothers as persons. *The Journal of Negro Education, 58*(1), 16–29.

US Department of Health and Human Services. (1975; Reissued, 1984; Reprinted 1992; Revised, 1996). *Head Start Program Performance Standards.* (DHHS Publication No.OHDS 84-31131). Washington, DC: US Government Printing Office.

Zigler, E., & Muenchow, S. (1992). *Head Start: The inside story of America's most successful educational experiment.* New York: Basic Books.

Do Parents See It Like Researchers Do? Coding of Videotaped Dyads by Low-Income African American and Latino Parents

Carla Beckford-Ogunleye, Jeanne Brooks-Gunn, Barbara Wallace, Julia Graber

PRESENTER: Carla Beckford-Ogunleye

Thirty-one low-income African American and Latino parents with young children in five Central Harlem Head Start sites watched, rated, and discussed videotapes of three different mother-child interactions. The study sought to determine whether parents would differ from student researchers on ratings of high- authoritative, high-authoritarian, and high-disengaged parent behavior. Parent ratings and focus group discussions provide some insight into the much debated issue of parenting among low-income African American and Latino parents.

(Abstract from original proposal; paper summary not available for publication)

Rx for Reading: Fostering a Collaborative Relationship Between Head Start and Pediatric Programs

Lisa Kraimer-Rickaby, Jane Goldman

PRESENTER: Lisa Kraimer-Rickaby

An ongoing concern of educators, as well as researchers and policy specialists in child development, has been the poor reading performance of a large number of children in the United States. More recently, pediatricians and other health care providers also have become concerned about literacy issues, and a number of pediatric clinics have begun to develop programs to foster emergent literacy skills. The purpose of this poster was to describe the Rx for Reading program developed at the Pediatric Ambulatory Clinic at Saint Francis Hospital and Medical Center in Hartford, Connecticut, and to encourage the development of collaborative partnerships between early intervention programs, such as Head Start, and pediatric clinics to foster emergent literacy skills in the families that these programs serve.

Saint Francis Hospital and Medical Center is located in an urban, low-income section of Hartford. Despite Connecticut's reputation for wealth and prosperity, Hartford has the 4th highest poverty rate in the nation. The state also has a staggering illiteracy rate: more than 340,000 (17%) adults in Connecticut are functionally illiterate.

The population served by Saint Francis Hospital and Medical Center reflects these high rates of poverty and illiteracy: 83% of participating children receive state assistance. In 1994, the Department of Pediatrics at the Saint Francis Hospital and Medical Center developed the Rx for Reading program to promote family reading activities among the parents and children seen at the pediatric clinic. As a part of the project, a multidisciplinary team of researchers in child development, pediatrics, and medical anthropology collected data concerning the reading behaviors, interests, and experiences of parents and children attending the clinic. Data from 51 parents were collected. By far the most significant finding in this study was that the parents were well aware of the importance of reading with their children. An overwhelming majority of the parents reported that they enjoy reading with their children, and many reported doing so on a regular basis. The data also revealed that 45% of the parents surveyed currently had children enrolled in a Head Start program in the Hartford area. Furthermore, 33% of the parents who did not have a child enrolled in Head Start at the time of the study reported that their children had been enrolled in the past. Of the parents surveyed, 70% reported that they were aware of a Head Start program in their area.

In light of these statistics, the need for comprehensive, collaborative community-based programs becomes more apparent. Pediatric and early childhood programs serve similar populations with similar needs. A collaborative relationship between Head Start and other early childhood programs and pediatric clinic-based programs would help ensure that parents and children have access to vital resources. The message of literacy promotion is intensified by the fact that families, especially those in the inner-city, place a lot of credibility and trust in their pediatricians and in programs like Head Start. Finally, a symbiotic and collaborative network of service providers can help assess, establish, and fulfill the respective goals of each program.

A Head Start on Science: Improving the Capacity of Families and Teachers to Promote and Enhance the Lives of Children

Penny L. Hammrich

PRESENTER: Penny L. Hammrich

The Head Start on Science (HSS) program is a 5-year program developed by the Laboratory for Student Success (LSS) to encourage science literacy of preschool children in Head Start programs and to improve the capacity of Head Start teachers, assistants, and parents. The overall goal of the HSS program is threefold: (a) to broaden HSS participants' science knowledge and conceptions, (b) to enhance participants' ability to use scientific inquiry, and (c) to integrate the HSS program with the core curriculum.

The HSS program is designed to serve as a field-based, staff-centered, professional delivery system that meets the support needs required by Head Start staff to broaden expertise in implementing science literacy and to redesign preschool learning environments into science-rich and student-centered settings. Through an intensive 2-week summer institute and a follow-up technical support program, the HSS program implements an integrated approach to developing science literacy and communication skills to further the learning of preschool children. Teaching scientific process skills improves the ability of participants to foster a fundamental set of "learning to learn" skills. This approach not only develops their ability for using process skills in self-directed learning, but also enhances their ability to engage in learning processes that require problem-solving.

Implementation of the HSS program began in 1996 with a 2-week summer institute that was conducted for 17 teams of teachers, assistants, and parents from Head Start programs in Pennsylvania and New Jersey. The aim of the summer institute was twofold: (a) to provide professional development for teachers, assistants, and low-income parents of preschool children through a science-rich, student-centered environment that emphasizes the development of appropriate skills and attitudes by using an inquiry approach to science literacy, and (b) to prepare participants to create a lifelong interest in science for themselves and the students. The institute incorporated Head Start science curriculum materials developed by the HSS program directors to assist teachers and parents to heighten and nurture children and families' willingness to learn. Overall, the summer institute encouraged participants to become more capable, comfortable, confident, and enthusiastic about learning their own and the children's "natural curiosity" about the world.

Follow-up support was provided to the institute participants in Year 2 of the project during the 1996-1997 academic year. Staff of the HSS program provided research-based information relevant to each Head Start program on what works as well as onsite visitation and consultation on needs assessment and identification of implementation barriers. In addition, HSS project staff developed site-specific technical assistance plans based on the analysis of needs by site personnel and implementation progress.

Replication of the HSS program will occur during Year 3 to 5 of the project in sites throughout the mid-Atlantic region. Future replication teams will be invited to visit the first cohort of Head Start on Science implementation sites and meet with the collaborating cultural and educational institutions to gain first-hand insight into the program.

Overall, the HSS program seeks to improve the capacity of families and teachers to promote and enhance the lives of young children in three specific ways: (a) ensuring that all children start school ready to learn, (b) enhancing teachers' abilities to foster the science literacy of children and parents, and (c) promoting partnerships to increase parental involvement and participation.

Findings from an ethnographic interview focusing on the teaching and learning of science and follow-up site visits showed that Head Start teachers, assistants, and parents have increased their ability to create and manage school learning environments that provide preschool learners

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with an opportunity to test their own ideas, engage in cooperative learning and exploration, learn from the ideas of their peers, and generalize from one context to another. Head Start teams have also transferred the science inquiry approach to learning both at home and in other educational environments, such as museums, zoos, aquariums, libraries, and other cultural and educational resources.

Follow-up visits to the first cohort of participating sites showed that HSS participants have increased their interaction with each other and with the children. Their classroom tasks have become more student directed, collaborative, and interactive. Participants are incorporating science activities into other learning situations, thereby fostering communication development. Children are asking more questions and communicating more with each other. Much has been accomplished since program implementation began in 1996, suggesting that expanding the Head Start on Science program could lead to even greater effectiveness of ensuring that children start school ready to learn.

Several policy and practical implications can be drawn from the work of the HSS program. First, Head Start programs must involve parents in their efforts to enhance the lives and learning of children and ensure that all children start school ready to learn. Parental behavioral expectations for their children have important long-term implications for children's "natural curiosity" to learn. Second, collaboratively involving teachers and parents in Head Start activities enhances children's capacity to learn in school and at home. Intervention programs designed to include parents and teachers have a strong and positive impact on promoting the readiness of children to learn. Third, program interventions evolve in stages of development, growth, and change. In order to promote the sustained readiness of all children to learn, support must be provided for collaboration among schools, parents, and the community as ideas for useful strategies are developed, implemented, and evaluated.

Empirical Relationships Among Parenting Styles, Determinants of Parenting, and Children's School Readiness Outcomes in Urban Head Start Families

Kathleen Coolahan

PRESENTER: Kathleen Coolahan

This study investigated relationships among parenting styles, determinants of parenting, and school readiness outcomes (peer play behavior, learning behaviors, and behavior problems) in urban Head Start families. The following questions were addressed: (a) Do parenting styles differ according to child age and gender, parent age and education level, and levels of life stress? (b) Do parenting styles relate differentially to the quality of children's peer play interactions, learning behaviors, and behavior problems? (c) Do parenting styles, in interaction with child age and gender, parent age and education level, and life stress levels, relate significantly to the quality of children's peer play interactions, learning behaviors, and behavior problems?

The target population was families in a Philadelphia Head Start program, 83% of whom are African American. Participants included 376 caregiver-child pairs from 30 classrooms. Classrooms were selected based on randomly determined participation in a teacher training program.

A number of measures were utilized. An adapted version of the Parenting Practices Questionnaire (PPQ; Robinson et al., 1995) was used to measure parenting styles. Coolahan (1997) found that this version yielded Authoritarian, Permissive, and Authoritarian parenting dimensions with urban Head Start families. The Penn Interactive Peer Play Scale (PIPPS; Fantuzzo, Coolahan, Mendez, McDermott, & Sutton-Smith, in press) was used to assess three dimensions

of preschool peer play: Play Interaction, Play Disruption, and Play Disconnection. The Preschool Learning Behaviors Scale (PLBS; McDermott, Green, Francis, & Stott, 1996) assessed Competence Motivation, Attention/Persistence, and Attitude. Behavior problems were measured with the Conduct Problems and Inattentive-Passive subscales of the Conners' Teacher Rating Scale-28 (CTRS-28; Conners, 1990), which assesses externalizing and internalizing behaviors, respectively. The Family Life Events Stress Scale was used to assess stressful life experiences (Coolahan, 1997).

A series of repeated measure ANOVAs was conducted. For each analysis, the PPQ dimensions served as the within-subjects factor and the hypothesized determinant variables were entered as blocking factors. PPQ-by-education and PPQ-by-stress interactions were detected. Permissive and authoritative parenting were associated with lower and higher education levels, respectively. Authoritative parenting was associated with lower stress levels, and authoritarian and permissive parenting were associated with higher stress levels.

Canonical analyses revealed that parenting styles related significantly to peer play behavior only. Authoritative parenting was positively associated with positive play interaction and negatively associated with play disconnection. Authoritarian and permissive parenting related negatively to positive play interaction and positively to play disconnection.

Through canonical analyses, interactions between parenting styles and four of the five determinant variables—parent education, child age, child gender, and life stress—were found to relate significantly to children's peer play behavior. Parenting styles in interaction with child age and gender also overlapped significantly with behavior problems. The association between authoritarian and permissive parenting and problematic peer and classroom behavior was greater when these parenting styles were combined with low parental education, younger children, male gender, and high stress. The association between authoritative parenting and positive peer and classroom interactions was enhanced by the presence of higher educational attainment and child age levels, female gender, and low stress.

References

Coolahan, K.C. (1997). *Empirical relationships among parenting styles, determinants of parenting, and children's school readiness outcomes in urban Head Start families*. Unpublished doctoral dissertation, University of Pennsylvania.

Conners, C. K. (1990). *Conners' rating scales manual*. Toronto, Canada: Multi-Health Systems, Inc.

Fantuzzo, J., Coolahan, K., Mendez, J., McDermott, P., & Sutton-Smith, B. (in press). Contextually relevant validation of constructs of peer play with urban Head Start children: Penn Interactive Peer Play Scale. *Early Childhood Research Quarterly*.

McDermott, P. A., Green, L. F., Francis, J. M., & Stott, D. H. (1996). *Preschool Learning Behaviors Scale*. Philadelphia: Edumetric and Clinical Science.

Robinson, C. C., Mandleco, B., Olsen, S., Bancroft-Andrews, C., McNeilly, M. K., & Nelson, L. (1995). *Authoritative, authoritarian, and permissive parenting practices: Psychometric support for a new measure.* Paper presented at the Biennial Meeting of the Society for Research in Child Development, Indianapolis, IN.

Relationships Between Peer-Play Behavior and Other Indices of Early School Adaptation in Urban Head Start Children

Kathleen Coolahan, Julie Mendez, John Fantuzzo

PRESENTERS: Kathleen Coolahan, Julie Mendez

This study explored relationships among three indices of early school adaptation in urban Head Start children: peer play behavior, early learning behaviors, and classroom behavior problems. The participants were 229 Head Start children in a large, northeastern city. The children were recruited from 14 centers that had previously participated in a pilot teacher training program. The sample was 87% African American, 9% European American, 3% Hispanic, and 1% Asian. Ages ranged from 44.8 to 71.8 months. Parents completed a demographic questionnaire, and teachers completed measures of peer play behavior and either learning behaviors or behavior problems on the participating children.

The study utilized three measures. The Penn Interactive Peer Play Scale (PIPPS; Fantuzzo, Coolahan, Mendez, McDermott, & Sutton-Smith, in press) was used to assess three dimensions of preschool peer play behavior: Play Interaction, Play Disruption, and Play Disconnection. The Preschool Learning Behaviors Scale (PLBS; McDermott, Green, Francis & Stott, 1996) was used to assess Competence Motivation, Attention/Persistence, and Attitude. Behavior problems were evaluated through the Conduct Problems and Inattentive-Passive subscales of the Conners' Teacher Rating Scale-28 (CTRS-28; Conners, 1990), which assess externalizing and internalizing behaviors, respectively.

The study focused on relationships between children's scores on the PIPPS peer play factors and dimensions of learning behaviors and behavior problems. Canonical variance and redundancy analyses elucidated the nature and extent of relationships between the PIPPS factors and the factors of the PLBS and CTRS-28. Regarding the PIPPS and PLBS, two significant canonical correlations (canonical R = .68 and .53) yielded the variates Positively Engaged and Non-Engaged, respectively (N = 229). The greatest overlap in the Positively Engaged variate was found between the PIPPS Play Disruption factor and the PLBS Attitude factor (with Play Disruption correlating negatively with the significant variate). For the Non-Engaged variate, the greatest overlap was detected between the PIPPS Play Disconnection factor and the PLBS Competence Motivation factor (with Competence Motivation correlating negatively with the variate). The Positively Engaged variate accounted for the greatest amount of variance (47%) of the overlap between these two measures. Redundancy analyses demonstrated that the PLBS factors accounted for 34% of the variance in the PIPPS factors. Alternatively, the PIPPS factors accounted for 40% of the variance in the PLBS.

The nature of overlap between the PIPPS and CTRS-28 factors was evident in the pattern of canonical loadings on the Acting Out-Disruptive and Passive-Disconnected variates associated with the two significant canonical correlations (canonical R = .77 and .67; N = 165). With respect to the Disconnected-Passive variate, the greatest overlap was between the PIPPS Play Disconnection factor and the CTRS-28 Inattentive-Passive factor. Squared canonical correlations showed that the Acting Out-Disruptive variate accounted for the greatest amount of variance (60%) of the overlap between these two measures. Finally, redundancy estimates indicated that the CTRS-28 factors accounted for 44% of the variance in the PIPPS factors, whereas the PIPPS factors accounted for 48% of the CTRS-28 factors.

Overall, findings from this study revealed meaningful relationships across constructs that inform our understanding of how children's peer play behaviors comport with other indices of preschool classroom functioning.

References

Conners, C. K. (1990). *Conners' rating scales manual.* Toronto, Canada: Multi-Health Systems, Inc.

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Fantuzzo, J., Coolahan, K., Mendez, J., McDermott, P., & Sutton-Smith, B. (in press). Contextually relevant validation of constructs of peer play with urban Head Start children: Penn Interactive Peer Play Scale. *Early Childhood Research Quarterly*.

McDermott, P. A., Green, L. F., Francis, J. M., & Stott, D. H. (1996). *Preschool Learning Behaviors Scale*. Philadelphia: Edumetric and Clinical Science.

When Head Start Children Fail Kindergarten: An Examination of Contextual and Individual Variables

Panayota Y. Mantzicopoulos

PRESENTER: Stacey Neuharth-Pritchett

Examined in this study was the extent to which nonpromotion at the end of kindergarten can be predicted from information about school and family contexts as well as children's individual characteristics. Because the available literature has not specifically addressed the issue of nonpromotion for former Head Start attendees, this investigation was guided by prior work in school readiness and retention-in-grade (i.e., Cadigan, Entwisle, Alexander, & Pallas, 1988; Mantzicopoulos & Neuharth-Pritchett, 1998; Reynolds, 1992).

Data were obtained during the kindergarten year from 11 schools and their kindergarten teachers as well as from 261 prior Head Start attendees and their parents in one school district with a Head Start/Public School Transition demonstration. Analyses examined the association of nonpromotion at the end of kindergarten with assessments of (a) school-related contextual variables; (b) the family-school connection; and (c) children's achievement, socioemotional, and demographic characteristics. Of particular interest was the extent to which Head Start children's school success was facilitated through participation in the Transition demonstration, a program that provided Head Start-like services in the public schools.

Promoted children had higher achievement scores and were rated by their teachers as better behaved and more socially competent than the nonpromoted children. In addition, parents characterized promoted children as having more positive attitudes toward school. The frequency of parent-reported school involvement was related to nonpromotion status. Effects were specific to those items that assessed the parents' concern for and engagement with their child. Frequency of parent-child communication about the child's daily school activities was related to positive school outcomes, a finding consistent with the interpretation that parent-child communication about school is one way through which parents facilitate the development of the child's abilities to meet the demands of school. However, there was a trend for nonpromotion to be associated with more frequent parent-teacher communication. In the absence of information about the content of these communications, this trend is difficult to interpret. On a post hoc basis, it seems that in some cases increased parental involvement may be a response to concerns about the child's school performance. In support of this inference, an earlier study identified a similar finding during the Head Start year (Mantzicopoulos, 1997). Thus, there is a need for research to explore the conditions under which various forms of parental involvement are related to children's adaptational outcomes.

Children attending demonstration schools fared better when it came to retention decisions. That is, Head Start children's school success was facilitated in schools that made efforts at providing Head Start-like services as children made the transition to kindergarten. Moreover, information about the schools' socioacademic environments contributed to the explained variance in retention outcomes. Schools with lower rates of free lunch eligibles and higher overall achievement tended to retain children with greater frequency.

In conclusion, the findings support the assertion that Head Start children's early school success is tied to school and family contextual factors as well as to children's individual characteristics. The study highlighted the need for support of public school programs that (a) emphasize educational and developmental continuity in the lives of children, (b) value the family-school connection, and (c) facilitate children's learning through flexible and appropriate instructional practices.

References

Cadigan, D., Entwisle, D. R., Alexander, D. L., & Pallas, A. M. (1988). First-grade retention among low achieving students: A search for significant predictors. *Merrill-Palmer Quarterly, 34*(1), 71–88.

Mantzicopoulos, P. Y. (1997). The relationship of family variables to Head Start children's preacademic competence. *Early Education and Development, 8*(4), 357–375.

Mantzicopoulos, P. Y., & Neuharth-Pritchett, S. (1998). Transitional first grade referrals: An analysis of school-related factors and children's characteristics. *Journal of Educational Psychology, 90*(1), 1–12.

Reynolds, A. J. (1992). Grade retention and school adjustment: An explanatory analysis. *Educational Evaluation and Policy Analysis, 14*(2), 101–121.

Does Head Start Prepare Children for Kindergarten? Evidence and Reflections From a Legislatively Mandated Impact Evaluation of Head Start in Ohio

Jerry Walker, Lindsey L. Ladd

PRESENTER: Lindsey L. Ladd

The primary evaluation method was a case study of 1,230 kindergarten students who attended the large urban Dayton public schools in the 1996-1997 school year. We compared former Head Start students with students whose preschool experiences were unknown and with those students who had been in federally funded Title I preschools. We used the following school readiness measures: literacy readiness, social competency, and attendance. We also observed Head Start classrooms, interviewed Head Start and kindergarten teachers, and reflected on our observations from studying Head Start for more than 2 years.

Based on our analysis, kindergarten students who had been in Head Start performed no better on any of the selected school readiness measures than comparable students whose preschool experiences are unknown. In addition, the Head Start group had significantly lower scores than the Title I preschool group on four of seven scales measuring literacy readiness and scored significantly lower on social competency.

We concluded that Head Start classrooms are well-organized and caring environments, providing a variety of learning experiences for children. However, Head Start classrooms place less emphasis on critical thinking, problem solving, and language and writing skills than other activities. Most kindergarten teachers hold low expectations for specific early reading and math skills for the children from this urban population. In general, there is little consensus among or between Head Start and kindergarten teachers about the academic expectations that should be held for early childhood learning.

We questioned whether there is enough clarity and consensus about school readiness goals, particularly goals that focus on the cognitive and language abilities necessary for school success. We concluded that Head Start needs to place increased emphasis on preparing children to be successful in school within its framework of developmentally appropriate practices.

Ohio Head Start: A Report on Children and Families

Lawrence J. Johnson, Debbie Zorn, Eric Baim, Nicole Doherty, Eric Dool, Melody Hayes, Krista Hill, Kelly Maples, Karin Nelson, Jennifer Ostrom, Sabrina Petrelli, Traci Prindle, Donna Ruiz, Maureen Simpson, David Tatem, Amy Van Buren, Nick Wilder

PRESENTERS: Victoria W. Carr, Lawrence J. Johnson, Janice E. Noga

This report documents a statewide evaluation of Head Start in Ohio. Its primary objectives were to identify developmental outcomes for Head Start children and to provide information on the Head Start experience pertaining to global aspects of children's lives, including education, health, parent involvement, and utilization of social services. Visits were made to a representative sample of Head Start programs in nine counties or clusters of counties throughout the state of Ohio to interview administrators about their programs and gather specific program data. A sample of children's files from each program was reviewed and used to determine a subsample of parents for in-depth interviews. A total of 550 files were reviewed and 209 parents were interviewed for this evaluation.

Although there are serious technical problems associated with current practices for measuring developmental outcomes, the data from this project clearly indicate that these Head Start programs had an important impact on the children served. Parents reported that Head Start helped prepare their children for kindergarten and alleviated concerns they had regarding the development of their children. Parents consistently noted that the developmental growth of their children exceeded their expectations, particularly social skills and independence/responsibility, the social competency skills most commonly identified in the literature as crucial for success in kindergarten.

The report documents the comprehensive nature of Head Start services and provides evidence of positive impacts for the whole family. Head Start helped families obtain appropriate medical services for their children, assisted families in obtaining medical insurance, and provided families with important information regarding child nutrition. Evaluation data indicated a greater degree of self-sufficiency in families being served by Head Start, with a 29% increase in the number of families having at least one parent employed and a 34% decrease in the number of families receiving public assistance over the course of the 1-year study.

The degree of family involvement observed in these programs was dramatic. The programs evaluated were able to document a range of 8 to 79 hours of volunteer work per family, with an overall average of 33 hours per family and a cumulative total of 180,000 hours. Such levels of involvement help explain the comprehensive impact of Head Start on the children and families being served and warrant further examination to determine whether the procedures being used could be replicated by other educational organizations to enhance family involvement in the education of children.

Clearly, the impact of Head Start is widespread and best understood from a comprehensive point of view. The data from this report indicate that the Head Start programs assessed had an important impact on both children and families. Moreover, these programs were tremendously successful in involving families at a time when the broader educational community is bemoaning decreasing levels of parental involvement and support. A deeper understanding of the holistic nature of Head Start practices may provide guidance to the broader educational community as it seeks to enhance the involvement of families in education.

Staff Development

Mutual Mentoring and Collaboration: Sharing Knowledge and Experience Within a Head Start Grantee Program

Jackie Post, Sally Lubeck

PRESENTERS: Jackie Post, Sally Lubeck

Teachers in Head Start, as in other programs or schools, often work in isolation from one another, carrying out their plans and working within the four walls of their classrooms. There is often little opportunity for sharing their experiences and expressing their concerns with others who are working in similar environments. Staff meetings are times for catching up on administrative details, participating in decision making at the program level, and attending special in-service training sessions on a variety of topics. There is little time for exchanging more than greetings and certainly not time for conversations of any depth.

For the last year, we have worked with a community of Head Start teachers and administrators in a rural Head Start grantee agency. The teachers work in classrooms scattered the length and breadth of a county. Our goal has been to find a way to reduce the teachers' isolation by providing opportunities for teachers to learn from each other and to examine ways for teachers to reflect upon their own practice. This was accomplished in ways outlined below.

A schedule and system was established that allowed teachers to visit each others' classrooms, while a researcher substituted for them in their own classrooms. During these visits, teachers had an opportunity to observe how their peers structured their classroom environments, established their routines, and handled situations that were both similar to and different from their own. These visits provided teachers with a chance to reflect upon their own practice as well as to sometimes offer assistance and suggestions to the teachers they visited.

The teachers and one of the researchers had extensive conversations after each session in which the researcher visited the classroom. Since teachers did not always leave their classroom to visit another, these conversations were often discussions about what had happened that day in the classroom. Through these conversations, teachers received support for their practice and ideas as well as an opportunity to explore new ways of thinking about their teaching.

The entire group met five times during the year. These meetings were a time for teacher sharing. Some of this sharing was done in the form of presentations teachers made on specific topics of their choice such as: creating a "worm farm," doing a mapping and transportation project, and making books with children. Through animated discussions and questions, teachers extended what others reported as well as expanded the discussion to related topics. Finally, these meetings provided a time when teachers could talk about where to acquire certain resources and ideas for rearranging the classroom and for field trips.

The various ways in which teachers shared with each other served as a mechanism for letting them think about their own teaching experiences and a way to provide support to each other. Together with the teachers, we have made plans to continue these activities in the coming year.

Reducing Psychological Trauma on Child Protective Caseworkers

Barbara Dane, Paula Fendall

PRESENTERS: Barbara Dane, Paula Fendall

Acknowledgment of child abuse and neglect has increased dramatically in the last 20 years. During this time, social agencies, schools of social work, and legal systems have maintained their mission to focus on the needs of families and children. At the same time, policies have shifted and innovative programs have been established. Although there has been an increase in awareness of the effects of child abuse on the victim and his or her family, there has been little focus on how child protective caseworkers who intervene are affected.

A substantial research literature has developed that documents the phenomenon variously called "secondary trauma" or "vicarious traumatization" (see, for example, McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Figley, 1996; Dutton, 1992). Prolonged and intense exposure to the traumas affecting clients, particularly where the injury and abuse is of human origin, has enduring psychological consequences. These may include emotional "numbing" or "glazing over;" psychosomatic manifestations, such as sleeplessness, headaches, and gastrointestinal (GI) distress; disassociation; intrusive imagery; and so forth.

This qualitative study sought to understand the impact of repeated exposure to child abuse and neglect on child protective caseworkers in the New York City Administration for Children's Services. Two focus groups provided a systematic method for collecting information from the caseworkers. A series of questions were formulated to guide the discussions. The main themes that emerged were grouped into five domains: (a) Coping-Secondary Trauma, (b) Child Fatalities, (c) Successful and Difficult Cases, (d) Organizational Stress/Burnout, and (e) Spiritual and Religious Beliefs.

The themes of the study were utilized to develop a curriculum to immunize workers against vicarious traumatization and to educate them regarding trauma syndromes and their treatment, the normalizing of responses, and the recognition of the impact of trauma material on their personal schema. A supportive and confidential environment was provided, and it was stressed that prevention and management of stress and trauma involve understanding boundaries between professional and personal activities.

The 2-day curriculum included nine key points: Normative Stress, Sense Desensitization, Parallel Response, Constructive Self-Development Model, Looking through a 3-Way Mirror, Coping, Paint Your Picture, My Personal Coping with Stress Chart, and Techniques in Deep Breathing, Massage and Music. Emphasis was on both didactic and experiential learning. Theories of burnout, countertransference, and secondary trauma were integrated into the training. A formal evaluation was utilized.

References

Dutton, M. A. (1992). *Empowering and healing the battered woman: A model of assessment and intervention.* New York: Springer.

Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary trauma stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

McCann, L., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131–149.

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy.* New York: W. W. Norton.

Developing A Partnership (DAP): A Head Start Parent Early Childhood Career and Employment Program

Elsa Brizzi, James D. Vogler, Beverly Morgan-Sandoz, Ceci Medina, Daryel Rhodes

PRESENTERS: Elsa Brizzi, James D. Vogler, Laura Whitney

Developing A Partnership (DAP) is a 9-month program in Los Angeles County, California, that prepares multicultural parent participants for a career and employment as preschool teachers and associate staff through training, professional growth, and accredited Early Childhood Education coursework. Eligible parents (Head Start parents who are recommended and supported by their delegate agency) are assessed and provided basic/remedial job-related training, support services, and job placement.

The DAP program works in collaboration with Cerritos College, 24 delegate agencies, and a state licensing institution (Partners) to provide early childhood education career development, certification, and employment.

An integral part of the training is ongoing volunteer time spent in agency classrooms with staff mentors. The teachers receive and provide input on how to work effectively with the parent as a trainee and later as a paraprofessional and peer in the classroom. All DAP training is available in each participant's first language.

To evaluate the outcomes of the DAP program, a survey was mailed to 200 parents from the 1994-97 program years. Fifty participants, or 25%, responded. The results are as follows:

1. Two thirds of the DAP graduates are employed in early childhood education.
2. Eighty-one percent of those are employed by Head Start Delegate Agencies.
3. Ninety-six percent of the DAP graduates feel Very Successful (57%) or Successful (39%) working in early childhood education.
4. One hundred percent of the DAP graduates feel Very Satisfied (71%) or Satisfied (27%).
5. One hundred percent of the DAP graduates feel that they were Very Prepared (66%) or Prepared (34%) by the DAP program to begin in early childhood education
6. Eighty-three percent of the DAP graduates enroll for further education after the DAP program.
7. Ninety-eight to one hundred percent of the DAP graduates believe that as a result of participating in the program they: (a) get along with their children, (b) have improved their parenting skills, (c) feel more confident in their own abilities, and (d) believe that they can be successful in school.

A Collaborative Consultation Model: Changing The Way Head Start Prepares Personnel to Work With Families at School, at Home, and in the Community

Susan H. Turben

PRESENTER: Susan H. Turben

"We must encourage Head Start to forge partnerships with key community and state institutions...and we must ensure that these partnerships are constantly renewed and recrafted to fit the needs of families..." (Shalala, 1994, p. 8). This edict accompanied the bipartisan reauthorization legislation, which created a broad set of recommendations to be fulfilled by Head Start in the 21st century.

Partnerships and community collaboration may be examples of what the future Head Start

will look like to the "outside" world, but how will Head Start teachers and staff see themselves "inside" Head Start centers and in families' homes? Will Head Start personnel be equipped to effectively employ collaborative partnership strategies with families?

This family-focused, activity-based training model evolved from an earlier grant, funded by the Ohio Department of Health, Bureau of Early Intervention, to prepare an 18-hour Early Intervention Personnel Verification Curriculum for professionals from 12 disciplines. The Verification Curriculum was successfully field tested with 230 professionals, including Head Start teachers, parents, and paraprofessionals.

Three promising effects were indicated: (a) Trainees demonstrated retention of collaborative and consultative working strategies at 6 months; (b) Participants reflected they routinely used the skill-based handouts in their day-to-day interactions with families; and (c) Professionals, regardless of level of experience, indicated they understood the meaning of "shared expertise" and felt more comfortable working with parents as partners rather than as "experts."

The collaborative consultation model views families as "being in charge." Teachers and paraprofessionals share their expertise with families but find ways to allow parents to have an equal role in the teaching and learning of their children. This collaborative design has been successful for elementary school programs (Thousand, Villa, Whitcomb, & Nevin, 1996). Early intervention programs have also used the model successfully in both home and classroom settings (Turben, 1997).

Six collaborative consultative skills form the nucleus of the training. Parent and professional cotrainers teach one collaborative consultative skill at each 90-minute session for 6 consecutive weeks. The sessions include: consultative-time scheduling, multisensory conversational instruction in the classroom, shared expertise with parents, child-family evaluation, collaborative brainstorming in the classroom and at home, and paired-response teaching.

The five-step method includes: a) cotrainers (a parent and a teacher) demonstrate the skill by telling a unique "family story" each week; b) take-home handouts on family concerns and child-related issues are reviewed; c) research on general issues affecting Head Start families is discussed; d) skills are practiced as family-centered activities that simulate "real-life" situations at home and at centers; e) activities are evaluated.

The "collaborative consultation" model appeals to Head Start personnel because the training answers the question, "What do I get out of it?" Teachers and staff receive resource information they can use daily, and they practice six practical skills they are able to integrate into their teaching. These skills promote self-development, group cooperation, and inclusiveness traits, which are essential if Head Start is to fulfill both the edict and promise that prompts legislators to reauthorize this program.

References

Shalala, D. E. (1993-1994). *Children Today, 22*(4), 4-8, 41. Administration for Children and Families, Department of Health and Human Services.

Thousand, J. S., Villa, R., Whitcomb, P. P., & Nevin, A. (1996). A rationale for collaborative consultation. In W. Stainback & S. Stainback (Eds.), *Support networks for inclusive schooling: Interdependent integrated education.* Baltimore, MD: Paul H. Brookes.

Turben, S. (1997). *A qualifying curriculum: Family-centered, activity-based curriculum for early intervention professionals* [Curriculum, CD ROM]. Mentor, OH: Turben Developmental Services Foundation.

"It's Not Gonna Fit Her Life!": An Approach for Teaching About Social and Cultural Context for Early Childhood Care and Education Professionals

Joanne Straceski

PRESENTER: Joanne Straceski

Debate has intensified within the field of early childhood education on the place of child development theory as authoritative knowledge for practice. One leader in the field has asked where all the "contention" has come from, observing that critics of child development theory have not come up with any good "replacements" (Katz, 1996). After 4 years of ethnographic fieldwork with a "two-generation" program aimed at improving the life chances of extremely poor families with very young children (Smith, 1995), I would maintain that the field of early childhood education is faced with a matter not of replacement but of addition. The challenge is how to draw usefully on the social sciences and humanities in order to broaden a framing of concerns that can inform professional practices. Revised NAEYC DAP guidelines (Bredekamp & Copple, 1997) reflect this awareness. This poster was intended to further such understanding.

In the poster, a vivid, accessible, and usable (Lindblom & Cohen, 1979) 9-page text was displayed. This text was a piece of creative writing in the form of a dialogue between two workers in a multiprofessional, multiservices setting, a form that represented an infrequently used approach to report on research findings. Part fabrication, the dialogue incorporated elements of actual talk and events. The text was intended as a potential heuristic or teaching tool and displays ways in which potentially difficult issues could surface within one particular context of "live things living" (Bronfenbrenner, Kessel, Kessen, & White, 1986, p. 1220). The approach to creating the text was influenced by Bowen (1954), VanMaanen (1988), Hooks and West (1991), and Bourgois (1995).

In the dialogue, an early childhood specialist and the staff ethnographer chat informally about various work experiences, such as accompanying a family counselor on a home visit and witnessing her show of disgust when approached by a small child bearing the gift of a shiny nutbrown cockroach; discussing a chance observation that the program's baby shower was a failure because "Black folks" prefer mixed-age children's birthday parties; sidestepping an argument with a program "expert" on what is best for a young mother with a little boy identified as having "gross motor" difficulties. As the talk unwinds, some unofficial, in-staff perspectives are woven in with more familiar early childhood talk about "teachable moments" and "child-centered activities." There are complexities in the content of talk that reflect forces that can have everything to do with the ability of early childhood staff to do their work. The issues can be subtle. In real life the problem can be how to get open in-house talk started in constructive ways.

The poster included running commentaries alongside the text. They "fattened" the portrayal of context complexities and introduced some key terms in contemporary lines of thought concerning the shifting salience of such dimensions of social identity as race, class, and professional commitment (e.g., Jenkins, 1996). Inviting conference participants to write in on the poster their own reactions, interpretations, and questions also served to model how professional conversations might evolve.

References

Bourgois, P. (1995). *In search of respect: Selling crack in El Barrio.* New York: Cambridge University Press.

Bowen, E. S. (1954). *Return to laughter: An anthropological novel.* New York: Harper & Row.

Bredekamp, S., & Copple, C. (1997). *Developmentally appropriate practice in early childhood programs.* Washington, DC: National Association for the Education of Young Children.

Bronfenbrenner, U., Kessel, F., Kessen, W., & White, S. (1986). Toward a critical history of developmental psychology: A propaedeutic discussion. *American Psychologist, 41*(11), 1218-1230.
Hooks, B., & West, C. (1991). *Breaking bread: Insurgent black intellectual life.* Boston: South End.
Jenkins, R. (1996). *Social identity.* London & New York: Routledge.
Katz, L. G. (1996). Child development knowledge and teacher preparation: Confronting assumptions. *Early Childhood Research Quarterly, 11*, 135-146.
Lindblom, C. E., & Cohen, D. K. (1979). *Usable knowledge: Social science and social problem solving.* New Haven, CT: Yale University Press.
Smith, S. (Ed.). (1995). *Two generation programs for families in poverty: A new intervention strategy.* Norwood, NJ: Ablex.
Van Maanen, J. (1988). *Tales of the field: On writing ethnography.* Chicago: University of Chicago.

Touchpoints and Head Start: Community Partnerships in Action

Maureen A. O'Brien, Elizabeth M. Beh, Claudia Quigg

PRESENTER: John Hornstein

This presentation discusses the development of a training model for multidisciplinary providers that emphasizes the building of supportive alliances between parents and professionals around key points in the development of young children. This train-the-trainer format has been developed for maximal outreach in the community and has been in existence since 1994. The Touchpoints Project is an outgrowth of Dr. T. Berry Brazelton's book, *Touchpoints*, which is based on his 40 years of pediatric practice and the relationships he formed with parents and children in more than 25,000 families. The Touchpoints model, which is conceptually based on the predictable bursts, regressions, and pauses in child development, is a form of outreach that engages parents around important information about their child's development.

The model proposes that the infant's developmental bursts are typically accompanied by behaviors that appear exaggerated or regressive, followed by a pause in which the new behavior is fully achieved. During these cycles, especially when the child's behavior becomes regressive, the potential for parental anxiety increases. Such anxiety can derail the child's development or even lead to neglect or emotional or physical abuse. These "touchpoints," therefore, are key opportunities for health care providers and other practitioners to collaborate with parents to reduce or prevent other problems in the family.

Equally important to the Touchpoints model is the relationship that must be developed and nurtured between the family and providers of care. The model is based on assumptions about parents and a philosophy of how to join them in the process of parenting in a preventive, strength-based, individualized manner. This combination of developmental information and relationship-building strategies is at the heart of the Touchpoints training model.

Of particular concern to us are families who may not return for intervention and care because they feel providers offer little that is pertinent to them. The model is especially aimed at underserved families who have not joined with the medical care or educational system because they have never felt a personal connection. The universality of child development and of parental passion for giving the child an optimal outcome makes these touchpoints unique opportunities to forge relationships with hard-to-reach parents. By combining anticipatory guidance, child development knowledge, and relationship-building skills, providers can more effectively collaborate with parents to bring about healthier brighter outcomes for children.

The Touchpoints model is currently underway in a dozen diverse communities across the country. Each has adapted the philosophy of Touchpoints—its assumptions about parents and providers as well as its guiding principles of practice—to the unique demands of the

community's parents. Touchpoints is currently being implemented and evaluated in remote communities, such as Gallup, New Mexico; in large, county-wide initiatives in California; and in many medium-sized communities. Goals for change range from the enhancement of individual providers' approaches to families to parent-focused and system-change outcomes. On the strength of Touchpoints training, communities are undertaking collaborations such as new university-agency partnerships, collaborations between health care systems and Head Start, and the development of a uniform parent handbook that is distributed to every new family in the community. These are examples of the powerful connections that are made when the community gathers around a "shared mission" of caring that is grounded in the developmental and relational principles of Touchpoints.

The goal of this paper is to provide an overview for the participants in the assumptions and principles that are at the heart of the Touchpoints model. The presenter will also serve as discussant, following the presentation of how Touchpoints looks in two diverse communities—one with Navajo Head Start families and one in a wider community collaboration between health and education in early childhood. This combination of theory and applied practice is critical to the Touchpoints perspective of putting established beliefs into action with families in need of support and information. At the conclusion of this symposium, participants should have a solid understanding of Touchpoints concepts as well as a sense of how the framework is being applied and evaluated in community partnerships.

A Model for Building Family-Centered, Integrated Teams

Adrienne Frank, Lisa H. Rogers

PRESENTER: Adrienne Frank, Michele Stuart

A family-centered team approach to services is important for young children and their families. A 5-step model of staff training helped more than 40 teams change their program practices. Teams with a variety of skill levels can successfully adapt and use this model to improve family-centered services, individualized planning, interagency collaboration, cultural competence, inclusion of children with disabilities, and program evaluation.

As a result of this session, participants will: (a) know the five steps of the Trans/Team model of in-service training to help teams use a more family-centered, integrated team approach to service delivery, (b) understand staff development/in-service strategies for successful change in service delivery practices, and (c) understand how to foster family participation in staff development and enhance the family's role as decision maker in designing service delivery.

To comply with performance standards and achieve recommended practice, many Head Start teams need to make changes in program/service delivery practices. Change does not come easily; it requires time, effort, and planning. Although most teams have the skill and knowledge to implement changes, a process for planning change is often lacking. This session will help participants to recognize the factors that help teams make desired changes and to identify strategies to help their own teams move towards a more family-centered, integrated team approach.

Teacher/Child Interaction

Building Teacher-Child Attachment Relationships as an Early Intervention Strategy With Behaviorally At-Risk Pre-K to Age 2 Children: Preliminary Findings of a 3-Year Pilot Outcome Study

W. Barry Chaloner

PRESENTER: W. Barry Chaloner

In this era of rapid change, education will be greatly affected as the number of undersocialized children continues to rise and our resources diminish. Educators are increasingly being asked to handle violent children without the skills to intervene. One often overlooked characteristic these behaviorally at-risk children share is an impaired bond with caregivers. The quality of adult-child attachment relationships in the early years is a critical factor for social bonding, resilience, emotional intelligence, substance abuse, violence prevention, and many aspects of brain development. Furthermore, research clearly suggests that having a secure attachment with a teacher can partially compensate for an insecure one with a parent. Research across disciplines supports "early school-based" intervention that includes three key elements: (a) positive teacher-student bonds, (b) clear, consistent boundaries, and (c) teachers giving language to the emotional "drivers" of student behavior. Unfortunately many intervention programs not only fail to approach these goals early enough or in a way that is developmentally appropriate to young children but miss addressing the attachment issue. The central intervention strategy used in this study is training teachers of pre-K to age 2 children to intervene using the three key elements listed above. Of the 18 children in the study, five were Anglo, eight were Hispanic, five were Native American and one was African American. Sixteen were males and two were females. Subjects were selected based on their pre-K to age 2 teacher's rating behavior using the Conners Teacher Rating Scale as pretests and posttests. To be considered at risk, each subject must have scored 65 T or higher in the pretest in at least two of five scales (two point code). Each subject was then posttested at the end of each of the following three school years. In the group considered to have demonstrated a significant reduction in risk, subjects showed a 10 point or more drop of T scores (one standard deviation or greater) in at least one or more scales on the first posttest and in two or more scales on the second and third posttests (two point code) without increasing T scores 10 points or more to 65 T or above in any of the scales that were below 65 T at the pretest. The same requirements applied to the group considered to have demonstrated some reduction in risk, but only one scale of the two or more that were elevated on the pretest needed to show and sustain a 10 point or more drop of T score points on the posttests. Of the 18 subjects, 13 or 72% showed and sustained a significant reduction in risk, 4 or 22% showed and sustained some reduction in risk and 1 or 6% showed no reduction in risk. Though this study is descriptive of quasi-experimental design with no control group and its findings are preliminary, it does suggest that bonding with a teacher who has been trained to give language in a developmentally appropriate way to a troubled child's inner feelings and beliefs during play, learning activities, and limit setting may be a key element in reducing risk for problem behavior and later violence as the literature suggests. Further research and study is needed to support these conclusions.

Relations Between Teacher Affect and Child Responses in a Model Early Childhood Setting

Kathleen E. Bigsby, Mellisa A. Clawson

PRESENTERS: Kathleen E. Bigsby, Mellisa A. Clawson

Teacher-child interaction in early childhood settings has been found to facilitate children's language development (McCartney, 1984). Previous research emphasizes the content of teachers' interactions with children (Honig & Wittmer, 1982); however, stylistic aspects, such as the teacher's affective tone, also may be influential, particularly in terms of motivating children to respond. Therefore, the purpose of the present study was to examine the relations between affective tone of teachers' interactions and children's responses.

The sample consisted of 83 preschool-age children (37 girls) attending a university-based preschool. Each child was observed over 100 rounds, and teacher affect and the child's response of each interaction were recorded. Teacher affect was coded as: (a) positive (i.e., friendly, pleasant), (b) negative (i.e., irritable, angry), or (c) neutral (i.e., inexpressive, flat). Children's responses were coded as: (a) positive (i.e., enthusiastic compliance), (b) negative (i.e., anger, aggression, or overt noncompliance), (c) passive (i.e., little to no affect demonstrated during compliance), or (d) ignore (i.e., no indication given of hearing the teacher accompanied by noncompliance).

Correlations revealed significant relations between child age and teacher affect. Specifically, older children were more likely to experience positive affect from teachers (r=.30, p<.05), whereas younger children were more likely to experience higher levels of neutral affect (r=-.73, p<.001). Furthermore, boys were marginally more likely than girls to experience negative teacher affect ($F(1, 54)$=3.61, p=.06). Analyses of children's responses revealed that younger children were more likely to use ignore (r=-.41, p<.001) and passive (r=-.64, p<.001) responses, whereas older children were more likely to exhibit positive responses (r=.28, p<.05).

To examine the relations between teachers' affective style and children's responses, partial correlations controlling for child age were computed. Positive teacher affect was related to children's positive (r=.89, p<.001), ignore (r=.32, p<.05), and passive responses (r=.28, p<.05). Neutral affect on the part of the teacher was related to children's passive (r=.79, p<.001) and ignoring responses (r=.52, p<.001). Negative teacher affect was not significantly related to children's responses.

Taken together, these findings suggest that the relations between teachers' affective style and children's responses during interactions are complex. Both are age-related in that older children are more likely to receive and communicate positively toned messages. Gender also plays a role in interactional experience; teachers were somewhat more likely to exhibit negative affect with boys. This finding supports previous research by Fagot (1984), suggesting that boys' day care experiences are characterized with higher levels of discipline, which may be accompanied by teacher irritability or anger. The findings also indicate that children's responses may be influenced by the affective style used by teachers. A pleasant and friendly tone on the part of the teacher may encourage enthusiasm and compliance by children. However, an inexpressive tone may encourage children to ignore or passively comply, neither of which facilitates children's communicative competence.

References

Fagot, B. (1984). Teacher and peer reactions to boys' and girls' play styles. *Sex Roles, 11*, 691–702.

Honig, A., & Wittmer, D. S. (1982). Teachers and low-income toddlers in metropolitan day care. *Early Child Development and Care, 10*, 95–112.

McCartney, K. (1984). Effect of quality of day care environment on children's language development. *Developmental Psychology, 20*, 244–260.

Insights From Persevering Teachers in Distressed Urban Environments

Beverly Hardcastle Stanford

PRESENTER: Beverly Hardcastle Stanford

In a grounded theory interview study of positive, persevering, veteran teachers working in some of the most distressed urban environments in the nation, insights were gained on how they endured so well. The elementary school teachers, all African American, working predominately or exclusively with African American students, offered perspectives on a major problem area today:

> No problem in contemporary America is more serious than the plight of children and youth in our decaying cities. Almost a quarter of the nation's children grow up in poverty....Without major, sustained, concerted efforts to work out these problems, the entire society will pay a terrible price. (Hamburg, 1992, p.1)

The study participants were also part of a group whose numbers are diminishing. According to Ladson-Billings, "In the twenty largest school districts, [children of color] make up over 70% of total school enrollment...[and] the numbers of teachers of color, particularly African Americans, are dwindling...[to] less than 5 percent of the total public school teaching population" (1994, p. x).

The participants were 10 teachers in two elementary schools in Washington, DC. Six teachers had taught 28-33 years (five of them had spent those years in the same urban elementary school) and four others had taught for 10-21 years. The participants also completed a Self-Anchoring Scale (Kilpatrick & Cantril, 1960), a metaphor questionnaire (Hardcastle, Yamamoto, Parkay, & Chan, 1985), and ranking activities. The researcher observed informally in the schools during the 5-week interviewing period. Three participants also engaged in a videotaped discussion of the initial findings.

Several dominant patterns emerged in the data: (a) the teachers' love of children; (b) their commitment to empower urban children as key reasons they persevered with high morale; (c) the fact that their work had become more stressful because parenting and parent involvement had changed drastically over the years; and (d) when discouraged, the fact that they gained strength through the support of their church, their faith, family members, and colleagues. Additional insights addressed needed strengths and supports, desired improvements, recommendations for teacher preparation programs, and specific guidance for others planning to teach in urban schools. Their perspectives differed in several ways from those the researcher discovered in an earlier study of teachers working with White and Latino students in less distressed environments (Stanford, 1994). In that study, the teachers' reasons for enduring were a deep love for students, the support of their principals, and collegiality. In the urban study, the teachers persevered because of their desire to empower the children in their challenging environments and found strength in their personal faiths and the support of their church communities.

Timing and demographics alert us to listen to these unique, persevering, urban educators, dinosaurs of experience and wisdom. We need to hear their voices before they leave the field. Their depth of commitment and passion for bettering the lives of the children they teach provide a model that should be celebrated, imitated, and multiplied in elementary schools in distressed environments.

References

Hamburg, D. A. (1992). *Children of urban poverty: Approaches to a critical American problem* (annual report). New York: Carnegie Corporation of New York.

Hardcastle, B., Yamamoto, K., Parkay, F. W., & Chan, J. (1985). Metaphorical views of school: A cross-cultural comparison of college students. *Teaching & Teacher Education, 1*(4), 309-315.

Kilpatrick, F. P., & Cantril, H. (1960). Self-anchoring scaling, a measure of individuals' unique reality

worlds. *Journal of Individual Psychology, 16*, 158–173.
Ladson-Billings, G. (1994). *The dreamkeepers: Successful teachers of African American children.* San Francisco: Jossey-Bass.
Stanford, B. H. (1994). A spirit of partnership: Qualities conducive to career perseverance and high morale in teachers. In M. J. O'Hair & S. J. Odell (Eds.), *Partnerships in education: Teacher education yearbook II* (pp.192–202). Fort Worth, TX: Harcourt Brace.

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Auspice Differences in the Characteristics of Teacher-Child Interaction

Scharman T. Grimmer, Mellisa A. Clawson, Tara Vaccaro

PRESENTERS: Mellisa A. Clawson, Scharman T. Grimmer

Previous research has indicated that children's early childhood experiences vary depending on center auspices. Specifically, nonprofit, when compared to for-profit centers, are characterized by higher levels of quality with respect to class size, teacher-child ratio, and teacher qualifications (Kagan, 1991; Phillips, McCartney, & Scarr, 1987). Perhaps more importantly, nonprofit centers are more likely to employ teachers who engage in child-sensitive interactions with children (Phillips, McCartney, & Scarr, 1987). Interactions between teachers and children are beneficial when they occur frequently and are positive in affective tone. Such interactions have been found to facilitate children's social competence (Holloway & Reichhart-Erikson, 1988). The purpose of the present study was to extend previous research concerning auspice differences by comparing the teacher-child interaction occurring in for-profit, nonprofit, and university-based early childhood facilities. It was hypothesized that teacher-child interaction would be most frequent, meaningful, and positive in university-based, followed by nonprofit, then for-profit settings.

Subjects were 83 children (37 girls) attending a university-based preschool program at a private university in the northeast, 122 children (56 girls) attending three for-profit programs, and 72 children (37 girls) recruited from two nonprofit centers. All children were between 24- and 60-months of age.

Teacher-child interaction was assessed using nonparticipant classroom observation in which each child was observed for a total of 100 rounds. Using stopwatches, observers recorded the time from the beginning of an observation until interaction with the teacher occurred. If no interaction took place within 120 seconds, "none" was recorded with regard to interaction and the observer proceeded to observe the next child. Interactions were coded with respect to rate, content, and affective tone. The rate of interaction was calculated as the total number of interactions a child experienced divided by the total number of rounds that the child actually was present. Content was coded as one of the following categories: custodial care, instruction, conversation, social facilitation, play, and control (see Table 1 for descriptions of each category). The affective tone of the teacher was coded as (a) positive (i.e., friendly or pleasant), (b) negative (i.e., unfriendly or angry), or (c) neutral (i.e., inexpressive or flat). Each type of affect was calculated as the ratio of that particular emotional tone to the total affect.

A series of one-way analyses of variance with appropriate follow-up tests (LSD method) was conducted in order to examine differences between auspices (see Table 2). An analysis of the overall rate of interaction revealed significant differences between all types of care, with children in the university-based center experiencing significantly higher levels of interaction with teachers (85% of the rounds present), followed by children in nonprofit centers (62%), then children in

for-profit centers (42%). Concerning content of teacher interaction, the experiences of children in the university center differed from those in for-profit centers in terms of significantly higher levels of custodial care, instruction, conversation, play, and lower levels of control. Children in nonprofit centers experienced higher levels of instruction, compared to children in the university setting. Furthermore, compared to children attending for-profit centers, those in nonprofit early childhood centers experienced higher levels of custodial care, instruction, and conversation. An analysis of teacher affective tone revealed that children in the university-based center experienced significantly higher levels of positive affect and lower levels of neutral and negative affect from teachers compared to children attending nonprofit and for-profit settings.

Taken together, the results of this study replicate previous research concerning auspices by revealing that children in nonprofit centers experienced more optimal teacher-child interaction, compared to children in for-profit centers. Furthermore, the university-based setting was characterized by the highest levels of quality with respect to the overall rate, content, and emotional tone of teacher-child interaction. Teachers in university settings tend to be highly trained to interact with children frequently and in meaningful and positive ways. They also are aware of strategies to use in facilitating children's learning through play, rather than adult instruction. The results of this study suggest that it would be useful for staff at university-based centers to involve themselves in community outreach programs that mentor teachers working in nonprofit and for-profit sectors. Doing so may improve the quality of care children receive across early childhood settings.

References

Holloway, S. D., & Reichary-Erickson, M. (1988). The relationship of day care quality to children's free-play behavior and social problem-solving skills. *Early Childhood Research Quarterly, 3*, 39–53.

Kagan, S. L. (1991). Examining profit and nonprofit child care: An odyssey of quality and auspices. *Journal of Social Issues, 47*.

Philips, D.A., McCartney, K., & Scarr, S. (1987). Child care quality and children's social development. *Developmental Psychology, 23*, 537–543.

Characteristics of Teacher-Child Interaction Experienced by Children for Whom English Is a Second Language (ESL)

Mellisa A. Clawson, Puisana Chau

PRESENTER: Mellisa A. Clawson

As early childhood programs become increasingly multiethnic, teachers find themselves working with greater numbers of children for whom English is a second language (ESL). Whereas previous research suggests that teachers may provide varying social climates depending on a given child's ethnic background, (Ogilvy, Boath, Cheyne, Jahoda, & Schaffer, 1992), the experiences of ESL children are not well understood. Therefore, the purpose of the present study was to examine the characteristics of the teacher-child interaction experienced by ESL children.

Subjects were 83 children (37 girls), ranging from 36 to 60 months of age (M=42 months) attending a university-based preschool. Nineteen percent (n=16) of the children were categorized as ESL, based on parents' answer to the question, "What language do you and your child usually speak at home?" Children present for fewer than half of the observation rounds were excluded from analyses.

Data collection took place in the form of classroom observations. The rate of interaction was calculated as the total number of verbal interactions the child experienced divided by the total

number of rounds that he or she was present (out of 100). Content of teacher interaction was coded as the one category reflecting its dominant theme. Categories were derived from a modified version of the scale developed by Innes, Banspach, and Woodman (1982) and included (a) custodial care, (b) instruction, (c) conversation, (d) social facilitation, (e) play, and (f) control. The teacher's affective tone during each interaction was coded as (a) positive (i.e., friendly), (b) negative (i.e., unfriendly or angry), or (c) neutral (i.e., inexpressive or flat).

A series of one-way analyses of variance was performed to examine the differences in teacher-child interaction experienced by English-speaking and ESL children. Results indicated that English-speaking children experienced interactions from teachers in approximately 89% of rounds, whereas ESL children experienced interaction in 77% of rounds (F (1,54)=3.21, p=.08). Concerning the content of interaction, ESL children were less likely to experience play behaviors from teachers, compared to English-speaking children (F(1,54)=11.74, p=.001), although both groups experienced similar levels of teacher interaction in the forms of instruction, conversation, play, social facilitation, and control. Analyses of teacher affect revealed a marginally significant difference in that ESL children were less likely to experience positive affect from teachers, (F(1,54)=2.91, p=.09).

Taken together, the results of this study indicate that ESL children may experience less optimal early childhood environments compared to their English-speaking peers in terms of less frequent verbal interactions, fewer play encounters, and lower levels of warmth from their teachers. These components of the early childhood environment have been identified as contributing to children's cognitive and social outcomes (Holloway & Reichhart-Erikson, 1988; Lloyd & Goodwin, 1995; Phillips, McCartney & Scarr, 1987; Vandell, Henderson, & Wilson, 1988). Although ESL children often do not show that they understand teachers' messages and have difficulties in effectively communicating their needs to teachers (Mattick, 1981), teachers must be sensitive to the needs of ESL children and provide them with an equally stimulating and warm environment.

References

Holloway, S. D., & Reichhart-Erikson, M. (1988). The relationship of day care quality to children's free play behavior and social problem solving skills. *Early Childhood Research Quarterly, 3*, 39–53.

Innes, R. B., Banspach, S. W., & Woodman, J. D. (1982). A comparison of the ecologies of day care centers and group day care homes for 4-year-olds. *Early Child Development and Care, 10*, 125–142.

Lloyd, B., & Goodwin, R. (1995). Let's pretend: Casting the characters and setting the scene. *British Journal of Developmental Psychology, 13*, 261–270.

Mattick, I. (1981). The teacher's role in helping young children develop language competence. In C. B. Cazden (Ed.), *Language in early childhood education* (pp. 83–96). Washington DC: National Association for the Education of Young Children.

Ogilvy, C. M., Boath, E. H., Cheyne, W. M., Jahoda, G., & Schaffer, H. R. (1992). Staff-child interaction styles in multi-ethnic nursery schools. *British Journal of Developmental Psychology*, 10, 85–97.

Phillips, D., McCartney, K., & Scarr, S. (1987). Child care quality and children's social development. *Developmental Psychology, 23*, 537–543.

Vandell, D. L., Henderson, V. K., & Wilson, K. S. (1988). A longitudinal study of children with day care experiences of varying quality. *Child Development, 59*, 1286–1292.

The Role of Teachers' Global-Mindedness in Classroom Communication Competency

Judy R. Walton

PRESENTER: Judy R. Walton

This exploratory quantitative study examined possible relationships between teachers' global-mindedness, their demographic characteristics, and the degree to which global-mindedness potentially influences teachers' intercultural communication. Classroom communication competence and global-mindedness were the only variables examined in this study. Teaching competency was not germane to this particular study. Global-mindedness is a worldview in which one sees oneself as connected to the world community and feels a sense of responsibility to its members. The globally minded person has an understanding of the long-term ramifications of his or her own behavior on the environment and global society and possesses a sense of efficacy in addressing world problems. His or her value system is reflected in his or her behavior.

Teachers in culturally diverse classrooms, a purposive sampling, were the unit of analysis. Two instruments, the Global-mindedness scale and Classroom Communication Inventory, were administered to 219 teachers. Two research questions examined (a) the relationship between teacher demographic characteristics (age, history of international travel, education, and religion) and multidimensional global-mindedness and (b) the influence of global-mindedness on teachers' classroom communication competence. Both instruments had high internal reliability consistency levels: Global-mindedness was .86 and Classroom Communication Inventory was .75. Significance was evaluated from three reinforcing perspectives: relationships, differences, and predictive effects.

Literature and survey results suggested that effective teacher-student culture communication and successful (goal) achievement became salient elements in the education of culturally diverse students. More importantly, the scholarly literature lacked documented research inquiries that examined teacher global-mindedness.

The majority of the sample were United States citizens (96%), female (83%), Christian (81%), and African American (61%). The results of the study confirmed that age, history of international travel, and religion are salient predictors to teachers' global-mindedness. Global-mindedness had a direct effect on teachers' classroom communication skills. When assessing the effect of global-mindedness on communication competency, we found that the stronger or more positive teachers' overall global-mindedness, the stronger or more positive their classroom communication competencies. The data also underscored the fact that African Americans are not monolithic.

Teachers' global-mindedness as influenced by age, history of travel or international residency, education, and religion confirmed many of the perspectives derived from the literature. Cultural pluralism, which is a global-mindedness dimensional indicator for valuing diverse cultures and an appreciation for exploring and understanding other cultures, and second language knowledge were associated with higher classroom communication competence scores.

From a theoretical perspective, successful student performance is contingent upon positive expectation and motivation from teachers. The literature underscored that expectancy-motivation's concepts are influenced by culture and cultural variations. Implicit also was the influence of teachers' global-mindedness. How teachers view their global community from which many of their culturally diverse students come will influence not only their expectancy-motivational perceptions but also their classroom communication competencies.

Various cultural variations in this study (i.e., age, second language, and religious affiliations) had shown their influence on teachers' global-mindedness and classroom communication competency.

In multicultural educational environments, these instruments could possibly be used in organizational needs assessment, self-assessment, training, intercultural communication and awareness evaluation, (teacher) empowerment and enhancement programs, and recruitment and hiring.

Developmentally Appropriate Practice Beliefs in Native and Non-Native American Head Start Education Coordinators

Melissa Werner

PRESENTERS: Melissa Werner, Jerry Alridge

Native American Head Start programs have survived and are flourishing at the cutting edge of a quiet revolution. They are engaged in efforts to keep tribal rituals, language and traditions alive. These programs provide opportunities for children to participate in language, instruction, teaching of tribal ways of being, and more importantly teaching of tribal ways of thinking, so children leave Head Start with experience and direct knowledge of their rich cultural heritage. This instruction about background and heritage is unique in young children in educational settings.

Concurrently with sharing the diverse cultural heritages which make up Native American Head Start programs, these child care programs are fulfilling another mission: preparing children for entry into public school. Few child care settings have such a complex task and none operate in a climate where the culture of the children attending is in danger of extinction. It is important to understand how programs are responding to the challenge of cultural transmission and school readiness.

One question in developing curricula for children attending Native American child care programs is the question of developmentally appropriate programming. The Head Start performance standards require provision of services to children that are developmentally and linguistically appropriate. Paul (1991) suggests Native American programs need to both succeed academically and preserve their culture.

The research purpose was (a) to describe developmentally appropriate practice beliefs of Head Start education coordinators from both Native and non-Native American programs, (b) to identify relationships between personal characteristics and developmentally appropriate practice beliefs, and (c) to describe the perspective of education coordinators from Native American Head Start programs with regard to transmission and the implementation of developmentally and culturally appropriate practice. Quantitative and qualitative analyses were used to identify relationships between variables with 376 participating Head Start program education coordinators.

The Teacher Beliefs Scale (Charlesworth, et al., 1993) was used to assess beliefs about developmentally appropriate practices. Principal component analysis resulted in six components. Discriminant analysis techniques were used to calculate components discriminating between Native and non-Native American Head Start program education coordinators. Bivariate analysis, multiple regression and backward variable selection were employed to identify noteworthy correlations between individual and program characteristics reported by Head Start education coordinators and Teacher Beliefs Scale scores.

Interviews, document review, and classroom observation were used with a subset of Native American education coordinators during site visits to obtain information about cultural transmission and developmentally appropriate practice. Qualitative data were analyzed using data gathering techniques and data analysis of phenomenological interviewing (Seidman, 1991). The descriptive statistics for the 376 Education Coordinators surveyed indicated the average educa-

tion coordinator in the sample was a 44-year-old Caucasian woman holding a bachelor's degree in education, including 118 hours of developmentally appropriate practice training. She had 15 years experience working with preschool children. The program where she was employed is rural and serves 326 children.

Data collected during site visits revealed several instructional approaches for teaching about local tribal culture that were the same across sites: inclusion of elders, nature as a tool for curriculum organization, tribal language instruction, stories and storytelling, and celebrations.

Elders were a valued part of the curriculum team at all sites. Their expertise was used to teach staff and children traditional ways. Seasonal variation of nature was an organizing tool in all sites. A central focus for transmission of tribal culture was tribal language instruction. Further, few or no children entered Head Start speaking the tribal language at any sites. All sites showed evidence of extensive Head Start and tribal efforts to support tribal language instruction in the Head Start preschool classroom. Stories and storytelling were part of the curriculum at all sites. These important tools were used to transmit tribal culture. Celebrations were a very important part of Head Start life at two sites. These sites hosted major community functions where children dressed in traditional clothing and families and communities participated.

At all sites there was an acknowledgment of sadness for how much culture has been lost. One teacher told of being taken away on a horse as a child, forced to attend boarding school. Her earlier memories were of riding on horseback, being tied to her grandmother so she could sleep and not fall off as her grandmother went out in the night over many miles to deliver babies. After she was at school, she could not see her grandmother for months and was not allowed to speak the only language she knew.

Further research is needed to describe developmentally appropriate practice beliefs of teachers and observation of instructional practices. Qualitative data gathered at additional sites would offer further insight about transmission of culture.

References

Charlesworth, R., Hart, C. H., Burts, D. C., Thomasson, R. H., Mosley, J., & Fleege, P. (1993). Measuring the developmental appropriateness of kindergarten teacher's beliefs and practices. *Early Childhood Research Quarterly, 8*, 255–276.

Paul, A. S. (1991). Early childhood education in American Indian and Alaska Native communities. In *Indian Nations at Risk Task Force Commissioned Papers.* (RC 018 612). Washington, DC: Department of Education. (ERIC Document Reproduction Service No. ED 343 761)

Seidman, I. E. (1991). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* New York: Teachers College Press.

Provider Attributes Associated With Quality of Care in Family Day Care Homes

Judith Bordin, Sandra Machida

PRESENTERS: Judith Bordin, Sandra Machida

Family day care homes continue to be the least regulated and most frequently used form of child care, especially for young children. This study measured family day care home quality in association with process and structural variables. Specifically, it sought information about the relationships between observed day care quality and provider characteristics, knowledge of child development and health information, and specific provider practices.

Thirty-one female providers were recruited from a master list of providers by a local child care resource agency. Day care quality was measured with the Family Day Care Rating Scale (FDCRS; Harms & Clifford, 1989), Global Rating Scale (GRS; Arnett, 1987), and the Home Observation for the Measurement of the Environment (HOME, Infant and Preschool Versions; Caldwell, 1987). Provider characteristics and current practices were ascertained by interviews and observations. Child development knowledge was measured by the Knowledge of Infant Development (KIDI; MacPhee, 1981). To further assess process quality, provider knowledge of health information was measured by a health questionnaire developed by two public health nurses.

Preliminary results indicated that the FDCRS was a robust indicator of overall day care quality. The GRS and HOME provided redundant information and were dropped from further analysis. Results indicted significant positive relationships between quality care and several provider characteristics. Specifically, provider college education was correlated to more learning activities and language reasoning. The provider being licensed was correlated with all the subscales of the FDCRS, except for social-emotional tone of interactions which approached significance. Specific child care training was significantly related to all the subscales of FDCRS except for use of space. Previous experience in providing child care was not correlated with overall program quality. Provider reports of where to seek information was related to FDCRS subscales of basic care, learning activities, and social-emotional tone. The range of topics covered in previous training was positively related to three of the five FDCRS subscales: learning activities, language and reasoning, and social-emotional tone.

Provider knowledge about early development, parenting, and child health were significantly correlated with observed quality. Further analysis revealed that knowledge about cognitive developmental milestones, sensitive parenting practices, and age-appropriate expectations were related to quality. Furthermore, provider knowledge about managing infection, prevention, and first aid were associated with all FDCRS subscales.

Reports of provider practices also revealed significant relationships with overall quality. Provider reports of the children spending less time viewing television, having indoor play areas separate from the family areas, and outdoor play space were positively related to quality.

The results from this study refocuses our attention on the provider. Within a cognitive mediational model, knowledge of child development guides provider beliefs and behavior to benefit those under her care. This study also reinforces the need to include structural aspects of quality, such as specific child care training and course work in child development in the evaluation of family day care homes. Both process and structural aspects of care warrant inclusion in the establishment of a higher level of quality in family day care.

Effective Instruction Across Task: The Use of Verbal and Nonverbal Teaching Behaviors Among Mexican American Mothers With Their Preschool Children

Robert P. Moreno

PRESENTER: Robert P. Moreno

Recent research has begun to challenge long-held views regarding the teaching strategies of Mexican American mothers. This research indicates that the instructional pattern associated with effective instruction among Mexican American mothers appears to be distinct from the effective teaching patterns of Anglo mothers, even when maternal education is taken into account (Moreno, 1991, 1997). However, it is unclear as to the extent to which this effective instruction pattern used by Mexican Americans generalizes across tasks.

The purpose of this study is to explore the teaching practices of Mexican American mothers across tasks (everyday vs. school related). The study focuses on two basic questions: (a) What are the differences in the teaching behaviors of Mexican American mothers in "everyday" and school related tasks? and (b) How do various teaching behaviors relate to their children's performance in each task? The sample consisted of 16 Mexican American mother/child dyads. The mean age of the children was 51.1 months (SD =7.8). The children were all normally functioning preschool children with no history of developmental delays or learning difficulties.

The findings indicated that Mexican American mothers do alter their teaching behavior according to task. The mothers teach their children using complementary modes of instruction. For example, while teaching a primarily nonverbal task (everyday), the mothers relied on verbal modes of instruction (i.e., commands, labeling, directives, and verbal corrections). Conversely, while teaching the more verbal-oriented task (school related), the mothers used more nonverbal instructional behaviors (i.e., visual cue, physical corrections). It may be that this complementary instruction reduces interference with the child's engagement of the task. The results also indicate that the more effective instruction is characterized by mothers who provide the most structure during the initial portions of instruction and withdraw as instruction progresses. This pattern appears to facilitate the child's takeover of the task. The results of this study may provide a much needed insight into the effective instructional practices among Mexican Americans. The findings may be used by researchers and practitioners to develop a culturally consistent educational curriculum that may in turn facilitate the educational achievement among Mexican Americans.

References

Moreno, R. P. (1991). Maternal teaching of preschool-age children in minority and low-status families: A critical review. *Early Childhood Research Quarterly, 6*, 395–410.

Moreno, R. P. (1997). Everyday instruction: A comparison of Mexican American and Anglo mothers and their preschool children. *Hispanic Journal of Behavioral Sciences, 19*(14), 527–539.

Effects of the Family Empowerment and Transitioning Program on Child and Family Outcomes

Pauline Davey Zeece, Aimin Wang

PRESENTER: Pauline Davey Zeece

Using a modified, cross-sectional, longitudinal design, the effects of Head Start (HS) and Head Start+Family Empowerment Transitioning Programming (HS+FETP) on 51 HS children and families were assessed for family risk and child developmental outcomes over a 3-year period. The Magura Family Risks Scales (MFRS) were used to measure the change in parent-centered, child-centered, and family economic risk over time. The Battelle Developmental Inventory (BDI) was used to evaluate children's developmental progress over five subdomains: personal-social, adaptive, motor, communication, and cognitive. Overall, HS and HS+FETP affected parent-centered and child-centered risk. While there were no significant group differences in the MFRS scores, a group by time effect in parent-centered and child-centered risk was noted for both programming groups. Parent-centered risk dropped for both groups: HS scores leveled and increased slightly at the end and HS-FETP continued a slow decrease throughout project duration. The mean child-centered risk scores showed a decrease over time for both groups. No significant group or group by time differences were found in the BDI data. There were significant time effects in all measures, except the adaptive subdomain. Significant linear and quadratic trends revealed both groups made progress in their personal-social development: HS group scores leveled off after the first posttest measure and HS+FETP scores kept increasing. Scores for HS+FETP children's motor, communication, and cognition kept increasing; HS children's motor and communication scores increased while their cognition scores dropped slightly. Usefulness of the MFRS and the BDI as HS program evaluation measures and implications for public policy were presented.

References:

Keyser, D., & Sweetland, R. (Eds.) (1985). *Test critiques*. Kansas City, MO: Westport Publishers.

Magura, S., Moses, B., & Jones, M. (1987). *Assessing risk and measuring change: The family risk scales*. Washington, DC: Child Welfare League of America.

Maxwell, K., & Eller, S. (1994). Children's transitions to kindergarten. *Young Children, 49*(6), 56–63.

Petrie, A., & Davidson, I. (1995). Toward a grounded theory of parent preschool involvement. *Early Child Development and Care, 3*, 5–17.

The Antecedents and Consequences of Grade Retention Among Children in a Head Start Transition Demonstration Program

Karen B. Taylor, Frances A. Campbell

PRESENTERS: Karen B. Taylor, Frances A. Campbell

Children's receptive language, academic performance in reading and math, teacher ratings of social skills, and examiner ratings of behavior during an assessment were compared in young children who were and were not retained in grade during the first 3 years in elementary school. Children's self-reported liking for school was also compared in retainees and nonretainees. Participants were 222 children in a Head Start Transition Demonstration Program. All were from low-income families. Eighty-one percent were African American, 13% were White, and the remainder were either Latino or "Other." The school system had a general policy of nonretention in the early grades, but officials nevertheless believed that "a few" children would benefit from repeating a grade. Within the present sample of children, 26 of 222, or 11%, were retained in the first 4 years. Half of these repeated first grade. Boys were more than twice as likely to be retained as girls, and approximately the same percentage of the total number of African American (12%) and White (14%) children were retained.

It appeared that readiness and ability were not major factors that distinguished those retained from those not, but those held back did make slower academic progress. Comparing raw scores for the Peabody Picture Vocabulary Test-Revised (PPVT-R; Dunn & Dunn, 1981) by retention group showed that, although children never retained had slightly higher raw scores in the 1st year, the difference was not statistically significant. These raw scores increased every year but they did not change differentially over time for retained and nonretained children. In contrast, analysis of transformed reading and mathematics scores from the Woodcock-Johnson Psycho-Educational Battery-Revised (Woodcock & Johnson, 1989) showed that those retained scored significantly lower across all years. Despite the lower scores in retainees, all children made progress at much the same rate in math, but nonretained children made significantly more gains in reading than retainees. Teachers rated retained children significantly lower than those not retained on social skills as reflected in the Social Skills Rating System (Gresham & Elliot, 1990).

Test administrators rated the children's ability to stay on task, to cooperate, and to comprehend questions and procedures. Children who were retained early ($N = 6$) scored well below the nonretained group on these examiner ratings, suggesting an immaturity in their approach to directed tasks. Children who were retained early suffered less drop in their self-rated liking for school (Reid & Landesman, 1988) than did those retained in the 2nd year, and they also made a dramatic recovery in their liking for school by the last year of data collection. The number of retained children is too small to permit us to do more than speculate on the meaning of these data, but it is a question that could be further explored in the full Head Start Transition Demonstration data set. Our data support earlier conclusions that grade retention does not appear to be an effective remedy for academic difficulties (Holmes, 1989; Shepard & Smith, 1990; Walters & Borgers, 1995).

References:

Dunn, L. M., & Dunn, L. M. (1981). *Peabody Picture Vocabulary Test-Revised.* Circle Pines, MN: American Guidance Service.

Gresham, F. M., & Elliott, S. N. (1990). *Social Skills Rating System.* Circle Pines, MN: American Guidance Service.

Holmes, C. T. (1989). Grade level retention effects: A meta-analysis of research studies. In L. A. Shepard & M. L. Smith (Eds.), *Flunking grades: Research and policies on retention* (pp. 16–33). New York: Falmer Press.

Reid, M., & Landesman, S. (1988). *What I think of school.* Seattle: University of Washington Child

Development and Mental Retardation Center.
Shepard, L. A., & Smith, M. L. (1990). Synthesis of research on grade retention. *Educational Leadership, 47*, 84–88.
Walters, D. M., & Borgers, S. B. (1995). Student retention: Is it effective? *School Counselor, 42*, 300–310.
Woodcock, R. W., & Johnson, M. B. (1989). *Woodcock-Johnson psycho-educational battery- revised*. Allen, TX: DLM.

Differences in Family Involvement Between Preschool and Kindergarten

Sara E. Rimm-Kaufman, Robert C. Pianta

PRESENTER: Sara E. Rimm-Kaufman

This cross-sectional study characterizes differences in family involvement practices in low-income families in preschool and kindergarten, examining patterns of family involvement in both grades and drawing inferences about changes across grades.

Relationships between schools and families play a critical role in children's adaptation to new school environments (Epstein, 1996), particularly among at-risk children (Pianta & Ball, 1993). Many preschool environments—Head Start programs in particular—expend great effort fostering family-school relationships. However, priorities shift when children reach kindergarten. As kindergarten teachers spend less energy maintaining family-school relationships, the nature of such relationships changes.

The purpose of this study is to characterize differences in family involvement practices in low-income families in preschool and kindergarten.

Teacher and family workers from two preschool programs and one kindergarten program kept records of their contact with family members of children in their classrooms for approximately 6 months. Preschool children (n=216) were selected for enrollment based on their low-income status and/or social or academic needs; 102 children attended a Head Start program and 114 children attended a state-funded program. Kindergarten teachers from the same school district kept similar records over the same time period for 86 kindergarten children who met the above criteria prior to preschool entry.

Teachers and family workers recorded every contact with the child's family. Teachers noted the date of each contact, with whom the contact occurred, who initiated the contact, the type of contact, the duration of the contact, and what topics were discussed.

Preschool contacts occur almost twice as frequently as kindergarten contacts. Mothers were equally likely to be involved in school-family contacts in preschool and kindergarten, but fathers were more likely to be involved in such contacts in kindergarten than in preschool. School-initiated contacts were more common in kindergarten compared to preschool. Conversations at school drop-off and pick-up, home visits, and phone calls were more common forms of contact in preschool than in kindergarten. Notes were more common in kindergarten than in preschool. Contacts lasting longer than 30 minutes were equally typical in preschool and kindergarten. However, shorter contacts (both those between 5 and 30 minutes and those less than 5 minutes) were more common in preschool than in kindergarten. Discussion of health problems, learning and academic problems, and social and behavioral problems occurred more often in kindergarten contacts than in preschool contacts.

Family involvement occurs more frequently in preschool than kindergarten. In kindergarten, fathers are involved in a larger proportion of the family-school contacts. A larger proportion of the contacts are initiated by the school rather than the home, notes are used more frequently as

means of communication, and family-school contacts are more likely to include discussions of children's problems.

These results suggest that family involvement in kindergarten is more formalized than in preschool. For example, where preschool parents may strike up quick, frequent contacts with their children's preschool teacher, parents of kindergarten children typically interact with teachers during formal progress reviews to discuss the child's school performance (especially problems). When casual contact does occur between kindergarten teachers and families, it most likely takes the form of exchanged notes.

These findings detail changes in family involvement that coincide with the transition into kindergarten. These changes reflect shifts in priorities as children begin formal schooling, and pose challenges for programs designed to enhance continuity between preschool and kindergarten.

References

Epstein, J. L. (1996). Advances in family, community, and school partnerships. *New Schools New Communities, 12*(3), 5–13.

Pianta, R. C., & Ball, R. M. (1993). Maternal social support as a predictor of child adjustment in kindergarten. *Journal of Applied Developmental Psychology, 14*, 107–102.

Teachers' Beliefs Related to Developmentally Appropriate Teaching Practices

Joseph T. Lawton, Linda J. Marshall, Charlanne FitzGerald

PRESENTER: Joseph T. Lawton

The objective of this study was to assess teachers' beliefs about teaching and to observe the practice of teaching during kindergarten through third grade in the context of developmentally appropriate practices of teaching. A number of factors were taken into consideration including definitions of developmentally appropriate teaching, descriptions of the organization of learning activities, teacher-child language during instruction, and teacher facilitation of children's learning.

It has been argued that teachers' beliefs about teaching should be an important focus of research (Pajares, 1992; Clarke & Peterson, 1986). However, Munby (1982, 1984) has commented that teachers' beliefs may not correspond to their practices due to intervening factors. A mandated element of the national transition study was the encouragement of developmentally appropriate practices (DAP) in the early elementary grades. Developmentally appropriate practice was described in terms of the guidelines for teachers published by the National Association for the Education of Young Children (NAEYC, 1992) which reflect a predominantly child-directed approach to teaching without eschewing the need for direct instruction. It can be expected that in developmentally appropriate classrooms, the language of instruction should include a balance between open-ended and direct questions and between direct and indirect statements, and the encouragement of children's questions, with acknowledgment of both content and process and with an emphasis on concept learning and problem solving.

The context of the study was the Central Wisconsin Head Start/Public School Transition Demonstration Project. The Wisconsin site was 1 of 31 sites included in a national study of the transition of Head Start children and families to public school funded through the Department of Health and Human Services. One major goal of Head Start is the facilitation of children's development and learning through active exploration and problem solving. Diminishing effects

of gains made in Head Start (Ainsa, 1989; Lee, Brooks-Gunn, Schnur, & Liaw, 1990) have been attributed to a less supportive environment in elementary schools (Alexander & Entwisle, 1988; McKey, Condelli, Granson, Barrett, McConkey, & Plantz, 1985).

Teachers completed a Teacher Belief Questionnaire (Lawton, 1992). Observations were made of: (a) the teacher-child language during instruction (Lawton, 1992) providing data on teacher and child use of questions and statements referring to content and process at a general and particular level and (b) teachers' facilitation of children's learning (Moely, Hart, Leal, Santulli, Rao, Johnson, & Hamilton, 1992) providing data on the organization and management of children's learning, use of questions, responses to children's learning, and suggestions for strategies for learning.

Although indicating a belief in the value of child-directed learning, teachers endorsed a balance between such learning and teacher-directed learning. However, they indicated that many constraints led to a major emphasis on teacher-directed learning. Classroom observations showed that the language of instruction focused on the acquisition of particular knowledge guided by teachers' predominant use of direct questions seeking for correct answers. Children's utterances consisted almost entirely of direct statements about content at a particular level and they asked few questions. Teachers' facilitation of children's learning focused on presenting particular procedures and specific information and acquisition of particular knowledge, accounting for 52% or more of teaching events.

There was little or no relationship between teachers' beliefs about teaching and their actual practices. The language of instruction and teachers' facilitation of children's learning is unlikely to promote concept learning and problem solving or the use of various strategies for learning. There was little or no evidence of curricula, classroom organization, or teaching practices that could be described as developmentally appropriate.

References:

Ainsa, T. (1989). Effects of computers and training in Head Start curriculum. *Journal of Instructional Psychology, 16*, 72–78.

Alexander, K. L., & Entwisle, D. R. (1988). Achievement in the first 2 years of school: Patterns and processes. *Monograph of the Society for Research in Child Development, 53*, (2, serial No. 218).

Bredekamp, S. (Ed.). (1992). *Developmentally appropriate practice in early childhood programs serving children from birth through age 8*. National Association for the Education of Young Children: Washington, DC.

Clarke, C. M., & Peterson, P. L. (1986). Teachers' thought processes. In M. C. Wittrock (Ed.), *Handbook of research on teaching (3rd Edition)*. New York: Macmillan.

Lawton, J. T. (1992). *Teacher-child language interaction: Classroom observation measure – revised version*. Madison: University of Wisconsin.

Lee, V. E., Brooks-Gunn, J., Schnur, E., & Liaw, F. (1990). Are Head Start effects sustained? A longitudinal follow-up comparison of disadvantaged children attending Head Start, no preschool, and other preschool programs. *Child Development, 61*, 495–507.

McKey, R. H., Condelli, L., Granson, H., Barrett, B., McConkey, C., & Plantz, M. (1985). *The impact of Head Start on children, families, and communities*. (Final Report of the Head Start Evaluation, Synthesis, and Utilization Project). Washington, DC.

Moely, B. E., Hart, S. S., Leal, L., Santulli, K. A., Rao, N., Johnson, T., & Hamilton, L. B. (1992). The teacher's role in facilitating memory and study strategy development in the elementary classroom. *Child Development, 63*, 653–672.

Munby, H. (1982). The place of teachers' beliefs in research on teacher thinking and decision making and an alternative methodology. *Instructional Science, 11*, 201–225.

Munby, H. (1984). A quality approach to the study of teachers' beliefs. *Journal of Research in Science Teaching, 21*, 27–38.

Pajares, M. F. (1992). Teachers' beliefs and educational research: Cleaning up a messy construct. *Review of Educational Research, 67*, 307–332.

Responding to Heterogeneity: Exploring the Effectiveness of Schools Serving Diverse Socioeconomic Populations

Linda J. Marshall, Joseph T. Lawton, Charlanne FitzGerald

PRESENTER: Joseph T. Lawton

Building on the literature related to differentially effective schools, this investigation sought to assess the viability of extending school-level variables to the experiences of individual children. In much of the effectiveness literature, socioeconomic status is treated as a school-level variable (e.g., percentage of children receiving free or reduced lunch) and schools are assigned to socioeconomic niches based on the average relative SES score of the students they serve. However, conclusions drawn based on the average SES of a school should not be equated with best practices for all SES subgroups that make up a school's population. Indeed, within-school socioeconomic variability may often exceed that found in cross-school comparisons.

The current investigation presents an individual-level analysis of child achievement within an SES category. A truly effective school is one that succeeds in promoting achievement in excess of expectations for children from all SES levels. Identifying these characteristics is vital if Head Start children are to maintain or build on the gains they make while in Head Start. Assessment of contextual characteristics and child outcomes involved collection of data from various sources including children, parents, and teachers. Based on self-reported family income and parent education level when the child was beginning kindergarten, families were assigned to either the low-SES or middle-SES category. Using this system, 77% of former Head Start attendees were classified as low SES and 23% were classified as middle SES.

Results indicated that low-SES children exceeded expectations when (a) both teachers and parents had high expectations for their general ability as well as their future achievement in both reading and math and (b) children were rated as better adjusted to school. Middle-SES children exceeded expectations when (a) both teachers and parents had high expectations for their general ability as well as their future achievement in both reading and math and (b) children were in classrooms where interaction was characterized by a higher percentage of children asking questions (as opposed to making statements) and a higher percentage of teachers asking divergent (as opposed to convergent) questions.

When individual-level analysis was used, many of the variables that had emerged in the school excellence literature also distinguished successful students from their classmates. Furthermore, many of these distinctions held for both low-SES children (predominantly former Head Start attendees) and middle-SES children. Parent and teacher expectations figured prominently for both groups, whereas adjustment to school proved to be particularly important for the low-SES group. Also notable were factors that failed to emerge as distinguishing characteristics, including school climate (Battistich; Solomon, Kim, Watson, & Schaps, 1995), teacher experience and attitudes toward teaching, child expectations, and most classroom interaction variables. The emergence of the adjustment factor for low-SES children further illustrates the importance of ensuring that Head Start children make a successful transition into the public schools. It also points to the need to identify programs or interventions that increase this level of adjustment.

Reference

Battistich, V., Solomon, D., Kim, D., Watson, M., & Schaps, E. (1995). Schools as communitites, poverty levels of student populations, and students' attitudes, motives, and performance: A multilevel analysis. *American Educational Research Journal, 32*, 627–658.

A Model of Long-Term Literacy Success Among Children Attending Head Start

Grover J. Whitehurst, Janet E. Fischel

PRESENTER: Grover J. Whitehurst

There is a significant mismatch between what many children bring to their first school experience and what schools expect of them if they are to succeed. This problem is strongly linked to family income. Combating this problem by enhancing preschool children's skills, motivation, health, and family support has historically been Head Start's primary goal. Given the diversity of Head Start children and the diversity of the schools they eventually attend, what are the variables that mediate and moderate long-term academic success? If answers to this question were available in a clear and interpretable form, Head Start programs would be better able to deploy their resources in ways that would maximize children's potential for success in school.

This poster addressed that goal with data from 443 Head Start children who graduated from Head Start during a 3-year period beginning in 1992. The youngest of these cohorts has just finished second grade. The children were assessed twice while in Head Start on an extensive battery of standardized language and emergent literacy tasks, and have been assessed annually since they have entered elementary school on a battery of standardized language and reading tasks. Head Start and elementary school teachers have provided annual assessments of each child's behavior and attention in the classroom. In addition, we have developed a measure of the mean efficacy of each of the 73 elementary schools attended by our sample so that the effects of Head Start children's post-Head Start schooling can be examined.

These data are being used to build a predictive model of individual differences in academic and literacy outcomes in elementary school. Among the findings are:

1. Emergent literacy abilities factor neatly into two domains: top-down language skills versus bottom-up prereading skills such as letter recognition and phonemic awareness. A strong link between language and prereading/reading exists in the preschool period, but weakens in kindergarten and disappears in first grade. Thus, interventions to increase language abilities must occur at age 4 or below if they are to transfer to prereading skills.
2. Prereading skills are by far the strongest correlates of early literacy success among low-income children, controlling, for example, over 60% of the variability in outcomes from kindergarten to the end of first grade. Thus, interventions to increase children's literacy success need to focus on specific bottom-up skills in addition to exposure to picture books.
3. Correlational studies of individual differences in emergent literacy and reading outcomes have missed large discontinuities in absolute levels of skills that are presumably a function of schooling.
4. Older children in a Head Start cohort are widely superior to younger children within that same cohort in prereading skills. By second grade, older and younger children are indistinguishable in reading skills.
5. The general efficacy of school districts into which Head Start children transition has a large effect on academic success of children who departed Head Start with similar levels of readiness.

Texas Head Start Transition Project: How Parenting Behaviors and Family Routines Affect Children's School Adjustment, Social Skills, and Achievement Scores

Lin Moore, David L. Brown

PRESENTER: Lin Moore, David L. Brown

Reviews of research have identified parental support as a critical factor in children's school achievement (Berreuta-Clement, Schweinhart, Barnett, Epstein, & Weikart, 1984; Gordon, 1977; Swick & Graves, 1991). Parenting behaviors are strong predictors of children's social competence (Maccoby & Martin, 1983). Effective parenting is characterized by nurturing and warmly emotional attachments, sensitivity to children's input, limited restrictiveness but a willingness to set rules, consistency, and structure (Baumrind, 1971). For children and adults, routines provide a predictable organization which promotes family strengths and buffers against stress (Jensen, James, Boyce, & Hartnett, 1983).

Parents of 109 third-grade children participating in the Texas Head Start/Public School Transition Project were interviewed during Spring, 1996. Your Child's Adjustment to School (Reid & Landesman, 1988) rated school progress. The Social Skills Rating System (SSRS) (Gresham & Elliott, 1990) generated subscales measuring children's cooperation, assertion, responsibility, self-control, and problem behaviors. The Parenting Dimensions Inventory (PDI; Slater & Power, 1987) produced subscales of nurturance, responsiveness to child input, nonrestrictive attitude, and consistency. The Family Routines Questionnaire (FRQ; Jensen, Sherman, Boyce, & Hartnett, 1983) provided frequency ratings of daily routines.

Individual assessments of children's academic skills were conducted in school settings. The Peabody Picture Vocabulary Test-Revised (PPVT-R; Dunn & Dunn, 1981) measured receptive vocabulary. The Woodcock-Johnson Psycho-Educational Battery-Revised (WJ-R; Woodcock & Johnson, 1990) measured letter-word identification, passage comprehension, calculation skills, and applied math problems. Children rated their school adjustment in What I Think of School (Reid & Landesman, 1988).

School adjustment was rated highly by both parents and children. Total scores for girls were significantly higher than for boys on both instruments. Girls scored higher than boys on every measure of achievement, with significantly higher scores on WJ-R passage comprehension and calculation skills.

Parents rated girls significantly higher on the Assertion subscale and lower than boys on the Problem Behaviors subscale. No significant differences were found in PDI or FRQ scores when ratings were compared by child gender. Homework patterns occurred weekly, but reading to children and evening quiet times were the least frequent family routines.

Your Child's Adjustment to School scores were significantly related to children's Total Social Skills and scores on the Assertion, Responsibility, and Self-Control subscales, while negatively correlated with Problem Behaviors. Parental and children's ratings of adjustment were also significantly correlated with the PPVT-R and the Woodcock-Johnson measures. Neither parenting behaviors (PDI) nor family routines (FRQ) were correlated with children's achievement scores.

Parenting behaviors (PDI) were significantly correlated with children's SSRS Total scores. Significant correlations were found between parents scoring high on the Nurturing subscale and children scoring high on Cooperation, Responsibility, and Self-Control subscales. The Responsiveness to Child score was significantly related to children's Assertion and Responsibility scores. Parental consistency was positively related to cooperation, assertion, and responsibility, and negatively correlated with problem behaviors.

The findings identified the strong links between positive parenting and socially adjusted children who liked school. Head Start and public school programs might focus on parenting

education that encourages positive, nurturing, consistent approaches, with expectations geared to children's developmental stages. Children's positive attitudes about school and the ability to get along well with teachers and peers appeared to provide foundations for higher academic achievement.

References:

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monographs, 75,* 43–88.

Berreuta-Clement, J., Schweinhart, L., Barnett, W., Epstein, A., & Weikart, D. (1984). *Changed lives: The effects of the Perry Preschool Program on youth through age 19.* Ypsilanti, MI: High/Scope Press.

Dunn, L. M., & Dunn, L. M. (1981). *Peabody Picture Vocabulary Test-Revised.* Circle Pines, MN: American Guidance Service.

Gordon, I. J. (1977). Parent education and parent involvement: Retrospect and prospect. *Childhood Education, 54(2),* 71–78.

Gresham, F. M., & Elliott, S. N. (1990). *Social skills rating system manual.* Circle Pines, MN: American Guidance Service.

Jensen, E., Sherman, A. J., Boyce, W. T., & Hartnett, S. A. (1983). The family routines inventory: Development and variation. *Social Science and Medicine, 17,* 210–211.

Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent-child interaction. In P. H. Mussen (Ed.), *Handbook of child psychology* (4th ed.; vol. 4, pp. 1–101). New York: John Wiley & Sons.

Reid, M., & Landesman, S. (1988). *What I think of school.* Seattle, WA: University of Washington.

Reid, M., & Landesman, S. (1988). *Your child's adjustment to school.* Seattle, WA: University of Washington.

Slater, M. A., & Power, T. G. (1987). Multidimensional assessment of parenting in single-parent families. In J. P. Vincent (Ed.), *Advances in family intervention, assessment, and theory* (pp. 197–228). Greenwich, CT: JAI Press.

Swick, K., & Graves, S. (1991). Empowering at-risk families during the early childhood years. Washington, DC: NEA.

Woodcock, R. W., & Johnson, M. B. (1990). *Woodcock-Johnson psycho-educational battery- revised.* Allen, TX: DLM Teaching Resources.

Focusing on the Strengths of Head Start Families

Rachel Becker-Klein

PRESENTER: Rachel Becker-Klein

Literature on Head Start families has focused on deficits, but these families exhibit many strengths and positive characteristics. The competencies of mainly African American Head Start families as reported by their family service workers are examined. Family strengths are used to predict child outcomes, such as achievement scores and adjustment to school.

(Abstract from original proposal; paper summary not available for publication.)

Black-White Differences in Early Literacy Skills at Kindergarten Entry: Race or Social Class?

Heather J. Bachman, Frederick Morrison

PRESENTER: Heather J. Bachman

Racial differences in academic achievement have been the topic of research and debate for more than 50 years, with investigators generally attributing this racial disparity to either qualitative, cultural differences (Ogbu, 1991; Alexander & Entwisle, 1988) or to inequitable socioeconomic situations (Schultz, 1993). The present study re-examined the nature and sources of racial differences in academic achievement. In addition, the independent and combined effects of SES, as measured by parental education levels, on children's literacy skills at kindergarten entry were also investigated. We hypothesized that as the amount of parental education increased, racial differences in children's academic performance would decrease.

A total of 262 kindergartners from Greensboro, NC, participated in the study. The sample was 42% African American and 58% White. Parent questionnaires included demographic information and the Home Literacy Environment Scale (Griffin & Morrison, 1997), a composite of nine literacy-related items (e.g., frequency of library visits, adult literacy-related behaviors, adult-child reading, and television viewing). Child IQ scores were obtained from the Stanford-Binet Intelligence Scale-Revised. Measures of interpersonal and work-related skills were assessed by teacher ratings on the Cooper-Farran Behavioral Rating Scale (1991). Children were also given tests of general information, mathematics, reading recognition (PIAT-R), and receptive vocabulary (PPVT-R). Two groups were formed to test the impact of increased parental education on children's academic achievement, with the low group having < 12 years of education (African American, n=62; White, n=36) and the high group having > 12 years of education (African American, n=47; White, n=117). Within both parental education groups, the African American and White families were equated on mean levels of education.

Although strong effects of both race and parental education level were found on all four literacy outcomes, none showed a significant race by education interaction; the racial differences remained consistent across increasing parental education levels. In an attempt to explain these unexpected results, the contributions of several child, family, and school factors were examined.

One potential explanation focused on differences in the home literacy environments provided by parents. Unlike the literacy outcomes, a significant race by parental education level interaction did emerge for the home literacy environment scores. However, African American parents with more than 12 years of education reported home literacy environments which did not exceed White families' scores at either level of parental education. Forced-entry regressions were conducted separately for African American and White families to determine the unique contribution of the home literacy environment after removing the effects of other important predictors. Results indicated that while the home literacy environment predicted significant, unique variance for White kindergartners' scores in receptive vocabulary (10%), general information (4%), reading recognition (4%), and math (2%), the home literacy environment did not contribute unique variance on any of the academic outcomes for African American kindergartners.

In summary, two central findings have emerged from this study. First, racial differences in children's early literacy skills did not decrease as parents' education levels increased. Secondly, substantial racial differences were discovered in the home literacy environments provided for these children, even at similar socioeconomic levels.

References:

Alexander, K. L., & Entwisle, D. R. (1988). Achievement in the first 2 years of school: Patterns and processes. *Monographs of the Society for Research in Child Development, 53*(2, Serial No. 218).

Griffin, E. A., & Morrison, F. J. (1997). The unique contribution of home literacy environment to differences in early literacy skills. *Early Child Development and Care, 127–128,* 233–243.
Ogbu, J. U. (1991). Low school performance as an adaptation: The case of Blacks in Stockton, California. In M. A. Gibson & J. U. Ogbu (Eds.), *Minority status and schooling: A comparative study of immigrant and involuntary minorities* (pp. 249–285). New York: Garland Publishing.
Schultz, G. F. (1993). Socioeconomic advantage and achievement motivation: Important mediators of academic performance in minority children in urban schools. *The Urban Review, 25,* 221–232.

Learning by Playing: Instruction in Key Thinking Abilities Through Play

Dennis Ciancio, Adrienne Sadovsky, Valerie Malabonga, Robert Pasnak

PRESENTERS: Dennis Ciancio, Valerie A. Malabonga, Robert Pasnak

By the end of preschool, some children have advanced to the period of transition from preoperational to concrete operations. Consequently, their thinking is becoming more abstract as their cognitive abilities grow (Piaget, 1968). Kindergartners developing more slowly have shown significant gains on achievement and ability tests (Pasnak, McCutcheon, Holt, & Campbell, 1991) when instructed in key thinking abilities such as unidimensional classification and seriation. Unidimensional classification is the ability to choose the odd member of a set of objects that is similar in all aspects but one. Children without this ability frequently misunderstand similarities and differences between objects.

Unidimensional seriation is the ability to order a set of objects along a continuum according to variations. Further, insertion of an object into a preformed series signifies even greater ability. Because many kindergartners are proficient in these skills, preparing a child before he or she might naturally acquire them may pave the way for complete mastery by eliminating erroneous tendencies before these tendencies impede progress. To test this rationale, normally developing 3-year-olds were instructed in unidimensional classification and seriation.

We transformed the learning set of Pasnak et al. (1991) which was "worklike" to 4-year-olds, to an age-appropriate "game" format. All games indirectly instructed the children in classification and seriation by requiring these abilities for success. The games were short and appealing to 3-year-olds to keep their interest.

Participants were 2 African American boys, 1 Caucasian boy, and 1 Caucasian girl (mean age= 3.5). A multiple baseline for single subject research was employed with four children. The logic of the multiple baseline design is that gains should be maximal on the cognitive domain taught during a given period if the learning set instruction is effective.

Games were constructed out of colorful materials such as pipe cleaners, cards, stickers, plastic figures, small rubber toys, felt, coloring books, marbles, books, crayons, and beads. Each game was carefully prepared ensuring that each would be appealing to this age group. Each child played one to three games per day, individually, for 15 minutes. The children were taught to classify objects according to size, orientation, category/color, and texture, and to seriate by size, length, width, and shade/texture.

The results indicate that both the seriation and the classification games were effective. The improvements children showed on tests were primarily and significantly in the domain on which they had just been instructed. Thus, the crucial requirement of this multiple baseline design, that gains in a particular ability would be most substantial after that ability had been the target for instruction, were well met by the results for all of the participants. It is evident that the learning set instruction in a game format was successful for each construct. These seriation and

classification abilities are likely to be strengthened rather than weakened as the children mature and have enriching experiences in their preschool environment. Hence, there is every reason to hope that the improvements in seriation and classification abilities will benefit the children in the years that lie ahead.

References:

Campbell, J., McCutcheon, L., Perry, P., & Pasnak, R. (1988). A preliminary test of Piacceleration instruction on the cognitive development of mildly retarded children. *Journal of Social Behavior and Personality, 3,* 225–230.

Pasnak, R., Hansbarger, A., Dodson, S., Hart, J., & Blaha, J. (1996). Differential results of instruction at the preoperational/concrete operational transition. *Psychology in the Schools, 33,* 70–83.

Pasnak, R., Madden, S. E., Malabonga, V., Martin, J., & Holt, R. (1996). Persistence of gains from instruction in classification, seriation, and conservation. *Journal of Educational Research, 90,* 87–92.

Pasnak, R., McCutcheon, L., Holt, R., & Campbell, J. W. (1991). Cognitive and achievement gains for kindergartners instructed in Piagetian operations. *The Journal of Educational Research, 85,* 5–13.

Piaget, J. (1968) *Six psychological studies.* (A. Tenzer and D. Elkind, trans.). New York: Vintage Books. (Original work published 1964).

Piaget, J. (1973). *The psychology of intelligence.* (M. Bercy and D. E. Berlyne, trans.). Savage, MD: Littlefield, Adams and Co. (Original work published 1947).

Southard, M., & Pasnak, R. (1997). Effects of maturation on preoperational seriation. *Child Study Journal, 27,* 255–268.

Waiss, S. & Pasnak, R. (1991). Instruction of young children on number conservation and unidimensional classification. *Bulletin of the Psychonomic Society, 31,* 205–208.

Family, School, Work: A Look at Parental Involvement During the Transition to Kindergarten

Wendy A. Goldberg, Rachelle Strauss, Alicia East

PRESENTER: Rachelle Strauss

Parental involvement in children's schooling has been acknowledged by researchers, educators, and policymakers to be a critical factor in children's academic success (e.g., Nord, Brimhall, & West, 1997; Steinberg, Lamborn, Dornbusch, & Darling, 1992; Stevenson & Baker, 1987). Indeed, the importance of parental involvement has been touted at the highest level of the federal government: In his 1997 State of the Union Address, President Clinton called for employers to grant employees time off from work to attend parent-teacher conferences.

In this study, data are reported on 92 mothers of kindergartners (43 boys and 49 girls). Women's ages ranged from 24-45 years (M = 34.98, SD = 5.11); most were middle class, college educated, and were living with a partner (82.6%). Approximately 80% of the children were Caucasian and 20% were Latino. Three-quarters (76%) of the mothers were employed for pay (n = 70). Mothers completed questionnaires concerning their involvement in their child's schooling, their work hours, and their workplace conditions.

The primary objective of this study was to examine links among work conditions, parental involvement in school, and aspects of family life. When parental involvement in school varied by demographic variables, results supported those of previous research (e.g., Stevenson & Baker, 1987; Zill & Nord, 1994): Mothers with higher educational attainment and mothers who lived in two-parent households were more involved.

Work hours and workplace conditions were also found to be associated significantly with

various types of school involvement. As their weekly hours of employment decreased, employed mothers were more involved in direct school activities such as attending parent-teacher conferences, going to special school events, and volunteering in the classroom. These findings might, at first blush, seem discouraging to mothers who work long hours. Although long hours of employment may compete unfavorably with the ability to be onsite at the child's school, weekly work hours were unrelated to mothers' involvement in cognitively stimulating activities in the home. Moreover, family-friendly workplaces did prove to be an important potential facilitator of mothers' involvement in activities at school. Helpful workplace conditions, such as ability to complete work at home, give employed mothers a window during conventional daytime hours in which they can attend parent-teacher conferences, see a school play, or help out in the classroom. Even among mothers who worked 35 hours or more per week, having a flexible, child-friendly workplace was associated with greater attendance at parent-teacher conferences and special school events. These findings offer support for the policy position that flexible, family-friendly workplace environments can provide a bridge between the settings in which families live, work, and learn.

References:

Bronfenbrenner, U. (1979). *The ecology of human development.* Cambridge, MA: Harvard University Press.

Coleman, J. S. (1991). *Parental involvement in education: Policy perspectives.* Washington, DC: US Department of Education, Office of Educational Research and Improvement.

Nord, C. W., Brimhall, D., & West, J. (1997). *Fathers' involvement in their children's schools.* Washington, DC: US Department of Education, National Center for Education Statistics, NCES 98-091.

Steinberg, L., Lamborn, S. D., Dornbusch, S. M., & Darling, N. (1992). Impact of parenting practices on adolescent achievement: Authoritative parenting, school involvement, and encouragement to succeed. *Child Development, 63,* 1266-1281.

Stevenson, D. L., & Baker, D. P. (1987). The family-school relation and the child's school performance. *Child Development, 58,* 1348-1357.

Zill, N., & Nord, C. (1994). *Running in place: How American families are fairing in a changing economy and an individualistic society.* Washington, DC: Child Trends.

Transition Effects on Children's Academic and Social Outcomes

Theresa C. Fox

PRESENTER: Theresa C. Fox

Research indicates mixed results on the long-term effects of the Head Start experience on child outcomes. The impact of transition services in extending longitudinal academic and social benefits to a group of African American, urban children was investigated. Dependent measures include achievement, school adjustment, grade retention, and special placements.

(Abstract from original proposal; paper summary not available for publication.)

The Michigan School Readiness Program Evaluation

Lawrence J. Schweinhart, Judy Florian, Ann Epstein

PRESENTER: Lawrence J. Schweinhart

The Michigan state preschool program, named the Michigan School Readiness Program (MSRP), provides a year of educational experiences to 4-year-old children who are identified as needing assistance in getting ready for kindergarten. The program is similar to Head Start in many ways, but has some important differences as well. Children and families enrolled in the MSRP have been documented with at least 2 of 25 identified factors placing them at risk for educational failure, including coming from a single-parent family and low parent education. During the 1996-1997 school year, programs operating in 460 of the state's 560 school districts and in 66 other agencies, most of which also provide Head Start, serve 21,638 children and their families throughout the state. Children receive a child development program that provides age-appropriate activities that promote intellectual and social growth. Their families receive parenting support, guidance, and referrals to community service agencies as needed. The High/Scope Foundation began the first evaluation of the implementation and impact of the state program during the 1995-1996 school year, funded by grants from the Michigan State Board of Education and the W. K. Kellogg Foundation.

The 1st first year of the longitudinal evaluation of MSRP uncovered some promising findings. First, MSRP participants were significantly more advanced in their cognitive, social, and emotional development than were comparison children. This result emerged consistently in both teacher and trained observer ratings collected when the children were in kindergarten. In some areas, the magnitude of the difference between the two groups' ratings is small, but statistically reliable, and, because the finding is replicated in every area assessed, we have confidence that the program enhances children's development overall.

Second, MSRP program quality, as measured by compliance with the Michigan state standards for preschool programs is very good. All of the intensively studied programs were of medium to high quality. The self-evaluations completed by all MSRP teachers also indicate good quality programs at all the sites. Third, preschool program quality was linked with several important areas of child development in kindergarten. That is, not only was MSRP effective for the at-risk children they served, but high-quality programs were found to promote children's development more than medium-quality programs.

Fourth, parent involvement was encouraged by the programs and a moderate amount of parent participation in program activities was demonstrated. Additionally, parent participation was related to children's development in kindergarten and parents' expectations for their children's future educational achievements.

The 1st year of the evaluation also resulted in some recommendations. The state legislature should construct guidelines for programs' use of funds and monitor program implementation to ensure children are enrolled in high-quality programs. The Michigan Department of Education should support the early childhood specialist position of the program and training for instructional staff because these areas are related to children's development after completing the program. Lastly, programs are encouraged to promote parent participation in their children's education, self-monitor their program quality, and evaluate the success of their recruitment procedures.

Boys' and Girls' Transition to School: How Are They Faring and Why According to Children Themselves, Their Parents, and Their Teachers

Robin Gaines Lanzi, Martha M. Phillips, Sharon Landesman Ramey, Craig T. Ramey

PRESENTER: Robin Gaines Lanzi

This presentation focused on 3,211 children (1,638 boys; 1,573 girls) participating in a national, prospective study of the transition-to-school process conducted in 30 independent sites. Data were gathered from children, family members, and teachers in the fall and spring of kindergarten and spring of first grade about children's transition-to-school experiences, family background characteristics, and resources. The following key questions were addressed: (a) To what extent do former Head Start boys and girls report positive school experiences? (b) To what extent do parents and children agree about children's early school adjustment as a function of child gender? (c) To what extent do teacher's ratings of children's adjustment to school differ as a function of child gender in kindergarten and first grade? and (d) To what extent are there systematic variations in parental anticipation of school adjustment difficulties between boys and girls?

As Table 1 indicates, girls were significantly more positive than boys in their ratings of three of the eight items from What I Think of School (Reid & Landesman, 1988a): how well they get along with their teacher ($x^2(2)=23.86, p< .001$), how much they like school ($x^2(2)=17.35, p< .001$), and how important doing well in school is to them ($x^2(2)=7.51, p< .05$). Table 2 depicts parents ratings of children's adjustment to school from Your Child's Adjustment to School (Reid & Landesman, 1988b). Across all items, parents reported better school adjustment for girls than for boys. Using the Academic Competence Scale of the Social Skills Rating System (Greshman & Elliott, 1990), teachers rated girls significantly higher than boys in their overall academic performance and classroom behavior in kindergarten and first grade ($p< .0001$). Girls appeared to be reluctant to report better actual performance in school, even though both parents and teachers reported more positive ratings for girls than boys. It is intriguing to note that boys and girls did not significantly differ in their standardized scores from the PPVT but did significantly differ in their rates of placement in special education (13% versus 9%, $p< .01$).

In terms of school adjustment difficulties anticipated by parents, 53% of the parents anticipated boys would have problems adjusting to school, whereas somewhat fewer (48%) parents anticipated girls would have problems. Specifically, the largest discrepancies were evident between parents' ratings of boys and girls in anticipation of disability-related problems (12% versus 7%), social and behavioral difficulties (22% versus 20%), and lack of school readiness (11% versus 9%).

The identification of more or less effective supports for adapting to the developmental transition-to-school and to environmental transitions may be valuable in helping former Head Start children, their families, schools, and communities cope with stressful demands and thus avoid negative lasting effects on children. Theoretically, boys and girls from diverse developmental levels and family settings have comparable needs for a strong and continuous support system and opportunities to develop and foster strong academic and social skills.

References:

Bowman, B. T. (1994). The challenge of diversity. *Phi Delta Kappan, 76*, 218–224.

Gresham, F. M., & Elliott, S. N. (1990). *Social Skills Rating System*. Circle Pines, MN: American Guidance Service.

Kagan, S. L. (1994). Readying schools for young children. Polemics and priorities. *Phi Delta Kappan, 76*, 226–233.

Ramey, S. L., & Ramey, C. T. (1992). Early educational intervention with disadvantaged children: To what effect? *Applied and Preventive Psychology, 1*, 131–140.

Ramey, S. L., & Ramey, C. T. (1994). The transition to school: Why the first few years matter for a

lifetime. *Phi Delta Kappan, 76,* 194–198.
Reid, M., & Landesman, S. (1988a). *What I think of school.* Seattle: University of Washington.
Reid, M., & Landesman, S. (1988b). *Your child's adjustment to school.* Seattle: University of Washington.

Early Relationship Quality From Home to School: A Longitudinal Study

Joan I. Vondra, Daniel S. Shaw, Laure Swearingen, Meredith Cohen, Elizabeth Owens

PRESENTER: Joan I. Vondra

Attachment theory has made critical contributions to the way we think about early caregiving relationships and their potential role in shaping other social relations and later socioemotional functioning (Bretherton, 1985). However, little work has been done to understand how the multiple relationships that characterize daily life within the family contribute to a child's "working mode" of relationships and to his or her subsequent functioning. The first question addressed in this study is whether nonmaternal relationships at home contribute unique variance—over and above the mother-child relationship—to the prediction of children's relationships with teachers, and socioemotional functioning more generally, in the early school years. For boys and for children of minority race, both of whom are at higher risk for school problems, supportive relationships within the family potentially play a more prominent role in predicting competence (Cohn, 1990; Egeland & Kreutzer, 1991; Norman-Jackson, 1982; Turner, 1991). The second question examined is whether relations at home—with mother and other adult caregivers and status among siblings—are more predictive of early functioning in school for boys, African American children, and/or children with insecure attachment relations to their mother.

Two hundred and twenty-three urban, low-income mothers with infants were recruited from the WIC Supplemental Nutrition Program. Mothers were seen with their child at the University at child ages 12, 18, and 24 months, and in the home between 15 and 18 months. Follow-up contact with mothers was completed by phone and mail when children were between ages 3 and 4, at which time mothers identified another adult ("alternative caregiver") with whom the child had a close relationship. This caregiver (40% grandparents, 28% other extended kin, 10% biological fathers, 28% maternal friends or sitters) was asked to complete a series of ratings about the child and their relationship. Teacher-child relationship data and data on child social functioning in the classroom were gathered when children were in kindergarten, first, and/or second grade.

Mother-child attachment security was assessed using the Strange Situation at 12 (Ainsworth/Main criteria) and 24 months (Crittenden PAA criteria). Based on relations to later school functioning, a continuous attachment "risk" score was created from both classifications. Sibling status was determined by mothers' choice of siblings for positive and negative descriptors (e.g., "Who gets along best in the family?", "Who has the hardest time getting along?").

Correlations among attachment risk, quality of alternative caregiver-child relationship, and sibling status indicated that these indices reflect different but somewhat related facets of social functioning in the home. Certain patterns of insecure attachment were associated with more negativity in the alternative caregiver-child relationship, but no such associations with the aggregate attachment risk index were found. However, global attachment risk predicted problem child or "black sheep" status indicated by mother at ages 3 to 4 years.

With respect to school functioning, attachment risk predicted greater teacher-child relationship dependency in kindergarten and first grade and less cooperation in first and second grades. Sibling status between ages 3 and 4 predicted school functioning primarily in kindergarten and first grade, including teacher-child relationship dependency and negativeness, and cooperation

and self-control in the classroom. Finally, a more positive relationship with the alternative caregiver between ages 3 and 4 predicted less negativity in the teacher-child relationship and more self-control in kindergarten and, in second grade, being liked versus rejected by peers. Associations using nonmaternal relationships were largely independent of attachment risk.

The only consistent evidence for the role of relationships as protective factors against social or demographic risk was for the boys in this study. Having a sibling who appeared to be a problem child in mother's eyes and having a more positive relationship with an alternative caregiver at preschool age predicted better social functioning in school for young boys only.

References:

Bretherton, I. (1985). Attachment theory: Retrospect and prospect. In I. Bretherton & E. Waters (Eds.), Growing points of attachment theory and research. *Monographs of the Society for Research in Child Development, 50* (1-2), 3-35.

Cohn, D. A. (1990). Child-mother attachment of 6-year-olds and social competence at school. *Child Development, 61*, 152-162.

Egeland, B., & Kreutzer, T. (1991). A longitudinal study of the effects of maternal stress and protective factors on the development of high-risk children. In A. Greene, E.M. Cummings, & K.H. Karraker (Eds.), *Life-span developmental psychology: Perspectives on stress and coping* (pp. 61-83). Hillsdale, NJ: Lawrence Erlbaum.

Norman-Jackson, J. (1982). Family interactions, language development, and primary reading achievement of Black children in families of low income. *Child Development, 53*, 349-358.

Turner, P. J. (1991). Relations between attachment, gender, and behavior with peers in preschool. *Child Development, 62*, 1475-1488.

The Impact of a Head Start-Public School Transition Program

Thomas M. Reischl, Jeanette M. Gassaway, Pamela P. Martin, Sandra J. Frassetto, Mona M. Ibrahim

PRESENTERS: Thomas M, Reischl, Jeanette M. Gassaway, Pamela P. Martin, Sandra J. Frassetto, Mona M. Ibrahim

An impact evaluation of the Head-Start Public School Transition Program in Muskegon Heights, Michigan was conducted. The impact the program made on parents and children was explored by including baseline data as children entered kindergarten and follow-up data collected in the spring of the kindergarten year and in the spring of first, second, and third grades.

(Abstract from original proposal; paper summary not available for publication.)

Welfare Reform

Case Management in Head Start Using the Lincoln Action Program's Family Assessment Tool

Brian Mathers

PRESENTERS: Beatty Brasch, Rutha Weatherl

The Family Assessment Tool (FAT) is the cornerstone of Lincoln Action Program's case management model. Lincoln Action Program (LAP) developed the FAT to serve as an assessment tool for identifying families' strengths and determining where the family may have barriers or service needs. The FAT targets outcomes, allowing social service programs to generate useful data regarding the efficacy of program services.

LAP conducted a series of Demonstration Projects to develop and refine their case management model and the FAT. These projects represent a union of service delivery and research. The demonstration projects were designed so that service outcomes could be verified and measured (and compared, in many instances, to data from families who did not receive the service). Third party (non-LAP) evaluators and consultants assured objective assessment of these projects. LAP did not evaluate their own data. The Gallup Organization and the University of Nebraska's Center for Children, Families, and the Law have both served as third-party evaluators for past and current demonstration projects at LAP.

The FAT is comprised of three basic elements: (a) a structured, holistic interview script for assessing families' strengths and needs; (b) a scoring guide to assist case managers in assigning a number rating for each life domain; and (c) the FAT Profile, which condenses assessment information onto a single page, providing a road map for family goal planning and information for program outcome data tracking.

Case managers conduct an initial FAT interview/assessment at the time of a family's entry into a case management service program. This interview establishes a baseline score for the family in each of the 21 life domains. The life domains measured include the following: (a) financial resources; (b) clothing/household goods; (c) adult medical needs; (d) disabilities; (e) support systems; (f) legal issues; (g) substance abuse (others); (h) substance abuse (self); (i) housing; (j) food/nutrition; (k) child medical needs; (l) child care; (m) educational needs; (n) parenting; (o) domestic violence (adults); (p) domestic violence (children); (q) transportation; (r) personal hygiene; (s) family planning; (t) child development; and (u) vocational readiness.

Based on the information gathered during the interview, the case manager assigns a number rating for the family in each of these 21 domains. The FAT scoring guide is used to determine which score is most representative of the family's relative strengths or barriers in each domain. A scale ranging from 1-6 is utilized, with a score of one indicating 'crisis' and a score of six indicating 'thriving.' Once each domain is scored, the ratings are transferred onto the FAT Profile. The case manager uses the Profile to proceed to the goal planning phase with the family.

After a period of service delivery (usually an interval of 6 to 9 months depending upon the program design), the case manager again conducts the FAT interview with the family and assigns scores in each of the 21 life domains. These second interval scores can be compared to the scores from the initial assessment, to determine areas where the family is making progress or to assess where new needs have arisen. Family goal plans are adjusted to reflect this updated information.

The Relationship Between Head Start and Stress Among Low-Income Parents Who Are Employed or Participating in Welfare Reform Programs: An Investigation of the Mediating Influence of Head Start

Maxine Freund, Cheryl Ohlson

PRESENTER: Cheryl Ohlson

This research study, an ongoing 2-year effort funded by the Department of Health and Human Services, Administration on Children, Youth and Families Head Start Research Scholars Program, focuses on the role of Head Start in the lives of low-income families within the context of a changing political and economic climate. The study examines the experiences of low-income parents who are employed or are participating in a welfare-to-work program and investigates the mediating influence of Head Start on the perceived stress levels of these parents. Specifically, researchers are examining the participants' perceptions of stress in their lives, focusing particularly on stressors related to employment, welfare reform, parenting, and child care.

Researchers are also investigating the participants' perceptions of the manner in which their participation in Head Start alleviates or exacerbates their perceived stress. Likewise, researchers are also seeking participants' recommendations regarding ways in which Head Start can be more responsive to the needs of low-income parents who are employed or involved in the welfare-to-work transition. Finally, an additional aspect of the inquiry involves parents who are employed or involved in a welfare reform program and who have a child on the Head Start waiting list. Researchers are examining the use of child care services among these participants, while also comparing their levels of perceived stress with those of the Head Start parents.

This study is grounded in an accumulating body of research that documents the relationship between poverty, parental stress, parenting behaviors, and children's social-emotional development. The documentation of these relationships indicates that early childhood programs that strive to support and enhance children's social-emotional development must focus not only on the children's mental health but also that of their parents and caregivers.

The study is being conducted in a small city adjoining a larger metropolitan area. Located in one of the first states to implement welfare reform policies, this city presents unique opportunities to examine the effects of these policies on low-income families with young children. The sample consists of 80 low-income parents, half of whom have a child attending the local Head Start program. The remaining half of the sample consists of parents who have a child on the waiting list for the Head Start program. Data collection and analysis include both qualitative and quantitative methodologies. The participants are interviewed using a structured interview format and complete three standardized stress-rating scales.

While quantitative data have not yet been analyzed, qualitative data reveal the emergence of several themes. Specifically, participants emphasize overwhelmingly the positive influence of employment and welfare reform in their lives (although researchers note that these participants have yet to lose their welfare benefits and, therefore, are currently receiving paychecks as well as public assistance). Many participants have also expressed frustration over their inability to obtain full-time employment that pays "livable" wages. Additionally, interviews with recent immigrants indicate that these families experience great difficulty navigating the various institutions and systems that could offer support, such as social services, Medicaid, and even Head Start. These families, as well as others, rely primarily on informal support systems.

Welfare: Its Impact on Child and Family Health

Grace A. Ophori, Marti V. Kennedy

PRESENTERS: Grace A. Ophori, Marti V. Kennedy

American family policy is emerging as a critical variable in child and family development. Throughout American history, welfare reform has been suggested to resolve the problems facing children in families. A review of family policy and welfare through the 20th century found that successful Head Start implementation requires changing the states' funding strategy. While there have been many studies on welfare reform that focused on different governmental approaches, family policy orientation, and funding strategies, these studies merely reflected the identification of problems. There have been few attempts to integrate a meaningful conceptual framework into the study of welfare reform. The purpose of this study is to contribute to the conceptual knowledge of welfare reform, and to assist decision-makers and family service professionals in thinking about welfare reform from the perspective of home economics.

One primary focus of welfare reform has been the Aid for Families with Dependent Children program (AFDC). This program was established during the Great Depression as part of the legislation under the Social Security Act (Gueron, 1996). From 1935 to the 1950s, direct financial support was provided to poor families to benefit their children. As a federal government program administered by the state, criteria for family eligibility and monetary entitlement were determined by the state.

Not only are benefits for those who do qualify inadequate, but the drastic reduction in AFDC grant levels, the vast discrepancies among states between their grant and need levels, and the new requirement that AFDC entitlement be based on a work mandate are also resulting in an increase in child poverty and an environment that is not conducive for child development in the 1990s. Solomon (1991) indicated that 38 states have AFDC benefits which are below 75% of the 1990 Census Bureau poverty threshold of $10,419 a year, for a family of three persons. The policy trend in the 1990s, with the restructuring of eligibility determinants, has in effect denied 2 million children AFDC benefits each year due to procedural requirements.

The Family Support Act of 1988 (FSA) and the Personal Responsibility Act established during Clinton's administration have had dramatic effects. A major component of the FSA is the Jobs Opportunity and Basic Skills Training Program (JOBS). The JOBS program required all AFDC recipients with preschool children to participate in the welfare-to-work program administered by the states. Although the program was funded to 1.3 million dollars in 1995, it has been criticized for promoting a narrow definition of short-term family training that has been ineffective in boosting the opportunity of the majority of AFDC recipients to enter higher-paying jobs. Welfare reform, as defined by the Clinton's administration, includes the Head Start Program among programs slated to lose entitlements status and funding resources under block grant. By the year 2000, the proposed funding reduction is estimated at approximately 1.2 billion dollars (Solomon, 1991).

Ensuring Head Start's success requires funding strategies that will enrich children's development. Further research is needed to identify those funding strategies that will most benefit government, Head Start, and children over time.

References

Gueron, J. (1996). Welfare reform. *Journal of Policy Analysis and Management, 15*(4), 547–561.

Solomon, C.D. (1991). *AFDC: Need standards, payment standards and maximum benefits.* Congressional Research Service (91–552 EPW). Washington, DC: The Library of Congress.

Relations of AFDC Use With Family Characteristics and Child Outcomes

Margaret R. Burchinal, Grace I. L. Caskie

PRESENTER: Margaret R. Burchinal

How to decrease welfare dependency has been the subject of a great deal of political and academic debate. Many factors hypothesized to influence welfare use have been identified including education, job training, subsidized child care, family size, and marital status. This study examined longitudinal data from low-income mothers and their children to identify predictors of varying usage patterns of Aid to Families with Dependent Children (AFDC) and how AFDC use relates to child outcomes.

Data on AFDC use were available from 113 mothers living in or near a Southeastern university town whose children had participated in one of two longitudinal projects: the Abecedarian Project or Project CARE. At the birth of their child, mothers of children in both programs tended to be young, African American, single, and undereducated. All had low incomes (many reported no earnings at all), with the average annual income at the child's birth being $3,077. A major part of the intervention program of the two studies involved randomly assigning children to receive high-quality, center-based child care. Data about the mothers' use of AFDC were collected at several points in their child's early childhood years (birth, 18, 30, 42, and 54 months) and school-age years (8 and 12 years). Demographic characteristics and maternal IQ (Wechsler Adult Intelligence Scale and the WISC-R for the few mothers younger than 16) were obtained at entry to the study and the demographic information was updated annually. All children were assessed with an age-appropriate, standardized, individually administered intelligence test between the ages of 6 and 96 months. The responsiveness and educational stimulation of the family environment were assessed annually from 6 to 54 months with the Home Observation for Measurement of the Environment (HOME).

Three AFDC use groups were defined as follows. The "Never" group did not receive AFDC at any time. The "Early Childhood" (EC) group received AFDC benefits at least once during the early childhood years (0-54 months), but did not receive AFDC during the school-age years (8–12 years). The remaining participants, the "Early Childhood and School-Age (ECSA) Years" group, were receiving AFDC during both the early childhood years and the school-age years. Overall, this last group was characterized by intermittent patterns of AFDC use, with only four mothers reporting use of AFDC at all seven data collection points. Analyses compared these three groups on demographic characteristics, stimulation of the home environment, and children's cognitive development.

Results indicate that mothers who never received AFDC were more likely to be older, married, have fewer children, and use greater amounts of child care than mothers who did receive AFDC. Child outcomes also varied with the use of AFDC and with participation in high-quality child care. Provision of quality child care for an extended period of time during the child's first 5 years of life appears to be a crucial factor both in reducing welfare dependency and improving child outcomes.

Long-Term Impacts of the Teenage Parent Demonstration: Children and Families Six Years Later

Ellen Eliason Kisker, Anu Rangarajan, Kimberly Boller

RESENTERS: Ellen Eliason Kisker, Kimberly Boller

The Teenage Parent Demonstration required all teenage mothers on welfare for the first time to participate in education, job training, or employment-related activities, regardless of the age of their child. To help them meet this requirement, the demonstration programs offered support services (primarily case management), and child care and transportation assistance. The demonstration was evaluated using an experimental design and included two follow-up studies, the first approximately 2 years after program intake and the second approximately 6 years after intake. During the demonstration (from 1987 to 1991), almost 6,000 eligible teenage mothers joined the welfare rolls in the three demonstration sites (Camden and Newark, New Jersey and Chicago, Illinois). Half of the teenage mothers were randomly assigned to participate in the programs; the remainder became part of a control group and received regular Aid to Families with Dependent Children (AFDC) services. The target population was diverse and included 76% African American and 17% Latino teenagers ranging in age from 11- to 19-years-old when they entered the demonstration program.

Results from the demonstration program showed that it is feasible to implement mandatory participation requirements and provide support services successfully at a modest cost. Clear expectations coupled with support services can increase participation in education and employment activities. In a short time, the programs increased participation in school, training, and jobs and increased child care use, but produced few significant changes in social and demographic outcomes (Maynard, Nicholson, & Rangarajan, 1993). After the demonstration programs ended, these impacts on mothers' activities faded. In addition, the programs did not produce any meaningful impacts on the mothers' living arrangements, subsequent births, father involvement and support, or maternal psychological well-being. Results suggest that improved education options and more intensive ongoing family planning services are needed to help teenage mothers improve their basic skills and employment prospects and postpone additional births (Kisker, Rangarajan, & Boller, 1998).

The demonstration also suggests that requiring mothers' participation in education or employment activities is neither harmful to nor helpful for children. At the time of the second follow-up, impacts on the development of the mothers' first-born children were examined. Interviews were conducted with 3,499 young mothers (85% of those sampled), and assessments completed with 2,096 children (78% of eligible children). Many key child and family constructs were measured, including parenting and the home environment, child cognitive well-being, child social and emotional well-being, and child physical health. No meaningful program impacts on the child and family outcomes examined were found. For example, the mean Peabody Picture Vocabulary Test-Revised (PPVT-R) score for children of mothers in the program was 79.9 and 79.0 for the control group. The children's mean scores on the PPVT-R and the Behavior Problems Index were lower than those of similar children nationally, indicating that the children in both groups were at risk for poor educational and social outcomes. To help children, more intensive, child-focused services are needed.

References

Kisker, E., Rangarajan, A., & Boller, K. (1998). *Moving into adulthood: Were the impacts of mandatory programs for welfare-dependent teenage parents sustained after the programs ended?* Princeton, NJ: Mathematica Policy Research.

Maynard, R., Nicholson W., & Rangarajan, A. (1993). *Breaking the cycle of poverty: The effectiveness of mandatory services for welfare-dependent teenage parents*. Princeton, NJ: Mathematica Policy Research.

One Year Later: The Impact of Michigan's "Work First" Policy on Head Start Families Receiving Government Assistance

Thomas M. Reischl, Rachel Schiffman, Mary Cunningham DeLuca, Martha York

PRESENTERS: Thomas M. Reischl, Rachel Schiffman, Mary Cunningham DeLuca, Martha York

The state of Michigan was among the first states to implement a policy that requires welfare recipients to work 20 hours a week to remain eligible for welfare benefits. The results of a survey study of a large sample (n>800) of Head Start and Early Head Start clients about the impact of this policy on their families 1 year after the implementation of Michigan's "Work First" policy are reported.

(Abstract from original proposal; paper summary not received for publication.)

APPENDICES

Cooperating Organizations and Program Committee

Cooperating Organizations

Ambulatory Pediatric Association
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Anthropological Association
American Cancer Society
American College of Preventive Medicine
American Educational Research Association
American Nurses Association
American Orthopsychiatric Association
American Pediatric Society
American Psychiatric Association
American Psychological Association
American Psychological Society
American Public Health Association
American Public Welfare Association
American School Health Association
American Sociological Association
American Speech-Language-Hearing Association
Association for Childhood Education International
Association of Black Anthropologists
Association of Black Psychologists
Association of Hispanic Mental Health Professionals
Association of Maternal and Child Health Programs
Association of Teachers of Maternal and Child Health
Association of Teachers of Preventive Medicine
Child Welfare League
Council on Anthropology and Education, Division for Early Childhood
Council for Exceptional Children, Division For Early Childhood
ERIC Clearinghouse on Elementary and Early Childhood Education
Family Resource Coalition
Federation for Children With Special Needs
International Society for Infant Studies
National Alliance of Business
National Association for the Education of Young Children
National Association of Elementary School Principals
National Association of Social Workers
National Association of State Boards of Education
National Association of State Directors of Special Education
National Association of W.I.C. Directors
National Black Child Development Institute, Inc.
National Black Nurses Association
National Center for Children in Poverty
National Center for Learning Disabilities
The National Coalition of Hispanic Health and Human Services Organizations
National Committee to Prevent Child Abuse
National Council for International Health
National Council of Jewish Women
National Council on Family Relations
National Fatherhood Initiative
National Head Start Association
National Latino Children's Agenda
National Medical Association
National Mental Health Association
Society for Adolescent Medicine
Society for Developmental and Behavioral Pediatrics
Society for Nutrition Education
Society for Pediatric Research
Society for Research in Adolescence
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Peer Reviewers

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Eurnestine Brown, Ph.D.
Melissa M. Brown, Ph.D.
Treeby Williamson Brown, M.A.
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Sheldon H. Horowitz, Ed.D.
Judy A. Howard, M.D.
Carollee H. Howes, Ph.D.
Colleen E. Morisset Huebner, Ph.D., M.P.H.
Janis F. Hutchinson, Ph.D.
Mark S. Innocenti, Ph.D.
Judith Jerald, M.S.W.
Debra Jervay-Pendegrass, M.A., Ph.D.
James E. Johnson, Ph.D.
Sheila Dove Jones, Ed.D.
Sheila B. Kamerman, Ph.D.
Susan Kessler-Sklar, Ph.D.
Anita F. Kieslich
Marsha A. Kreucher, B.A.
Michael E. Lamb, Ph.D.
Catherine G. Lane, M.P.H.
Luis M. Laosa, Ph.D.
Joseph T. Lawton, Ph.D.
Irving Lazar, Ph.D.
Robert K. Leik, Ph.D.
Martha Lequerica, Ph.D.
Michael Lewis, Ph.D.
Carol S. Lidz, Psy.D.
Sharon K. Long, Ph.D.
John M. Love, Ph.D.
Patricia G. Mace, Ph.D.
Anthony P. Mannarino, Ph.D.
Rebecca A. Marcon, Ph.D.
Barbara L. Marino, Ph.D.
Nancy L. Marshall, Ed.D.
Silvia Martinez, M.S.
Peg M. Mazen
Rosemary D. Mazzatenta, M.S., B.S.
John H. Meier, Ph.D.
Samuel J. Meisels, Ed.D.
Matthew Melmed, J.D.
Barbara Merrill, M.S.
Shelby H. Miller, M.A.
Janice M. Molnar, Ph.D.
Carolyn Morado, Ph.D.
Laurie A. Mulvey, Ph.D.
Beverly A. Mulvihill, Ph.D.
Rebecca S. New, Ed.D.
Sherri L. Oden, Ph.D.
Jean H. Osborn, M.A.
Joy D. Osofsky, Ph.D.
Margaret T. Owen, Ph.D.
Kathleen D. Paget, Ph.D.
Judith S. Palfrey, M.D.
Barbara A. Pan, Ph.D.
Patricia H. Papero, Ph.D.
Jane L. Pearson, Ph.D.
Cassandra Peters-Johnson, Ph.D.
Susan G. Pickrel, M.D., M.P.H.
Luzanne B. Pierce, M.A.T.
Adele Proctor, Sc.D.
Arnaldo J. Ramos, Ed.D.
Gary Resnick, Ph.D.
Tommie L. Robinson, Jr., Ph.D.
Lori A. Roggman, Ph.D.
Victoria R. Seitz, Ph.D.
Daniel D. Shade, Ph.D.
Terri L. Shelton, Ph.D.
Milton F. Shore, Ph.D.
Mary Lou de Leon Siantz, Ph.D.
Robert G. St. Pierre, Ph.D.
Martha D. Staker, R.N., M.S., M.A.
Dorothy M. Steele, Ed.D.
Harold W. Stevenson, Ph.D.
Howard C. Stevenson, Ph.D.
Zolinda Stoneman, Ph.D.
Sara Stoutland, Ph.D.
Jean Ann Summers, Ph.D.
Susan Taylor-Brown, Ph.D., M.S.W., M.P.H.
Henry Tomes, Ph.D.
William Douglas Tynan, Ph.D.
Amy Powell Wheatley, Ph.D.
Sheldon H. White, Ph.D.
Janice M. Wright, M.A.
Lois E. Wright, M.S.S.W., Ed.D.
Martha York, B.A.
Caroline Zinsser, Ph.D.

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DIRECTORY OF PARTICIPANTS

Abbott-Shim, Martha S. 145, 152, 466, 551, 581
Georgia State University
Education Psychology and Special Education
University Plaza, Suite 367
30 Pryor Street
Adult Literacy Center
Atlanta, GA 30303-3083
mabbottshim@gsu.edu

Abdul-Kabir, Saburah
University of Pennsylvania
Graduate School of Education
Psychology in Education Division
3700 Walnut Street
Philadelphia, PA 19104-6216
saburahak@gse.upenn

Abramson, Lauren 561
Johns Hopkins University
624 North Broadway, Room 800
Baltimore, MD 21205
Labramso@weLchLink.weLch.jhu.edu

Aburime, Tony-Adams 469
P.A.C.E. Head Start
710 Katie Avenue
Hattiesburg, MS 39401

Aceves, Consuelo 332, 333
Harvard University
Graduate School of Education
Larsen Hall, #322
Appian Way
Cambridge, MA 02138
acevesco@hugse1.harvard.edu

Achhpal, Beena 611
University of Connecticut
School of Family Studies
345 Mansfield Road, U-58
Stors, CT 06269
achhpaL@uconnvm.uconn.edu

Adams, Marilyn A.
Milwaukee Public Schools
3910 West Clinton Avenue
Milwaukee, WI 53209

Ahmed, Marlene Major 582
Harvard Graduate School of Education
Appian Way
Cambridge, MA 02138
ahmedma@hugse1.harvard.edu

Ajuda, Poonam 130
New York University
239 Greene Street, 4th Floor
New York, NY 10003

Alarcon, Odette 251, 254
Wellesley College
Center for Research on Women
106 Central Street
Wellesley, MA 02181

Albro, Elizabeth R.
Whittier College
13406 Philadelphia Street
Whittier, CA 90608
LaLbro@whittier.edu

Allbritten, Dorothy J.
Office for Children
Head Start Program
12011 Government Center Parkway
Suite 920
Fairfax, VA 22035

Allen, Sharon M. 160
University of South Dakota
School of Education
414 East Clark Street
Vermillion, SD 57069
saLLen@sundance.usd.edu

Allen, Velma 72, 73, 82
Mott Children's Health Center
806 Tuuri Place
Flint, MI 48503

Alridge, Jerry 645
University of Alabama at Birmingham
School of Education
Curriculum and Instruction
Birmingham, AL 35294

Altfeld, Susan J. 547
The Ounce of Prevention Fund
122 South Michigan Avenue, #2050
Chicago, IL 60603
saLtfeLd@Lucidum.com

Amodei, Nancy 529
The University of Texas
Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284
amodei@uthscsa.edu

Amwake, Carolynn P.
SERVE
1203 Governors Square Boulevard,
Suite 400
Tallahassee, FL 32301

Anderson, Elaine 563
University of Maryland
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742-7515
ea8@umaiL.umd.edu

Anderson, Genan T. 462
Brigham Young University
1319 SFLC
Provo, UT 84602
genan_anderson@byu.edu

Anderson, Karen M.
American Psychological Association
750 First Street, N.E.
Washington, DC 20002
kanderson@apa.org

Anderson, Norman B. 3, 6, 9, 10, 12
NIH/OD/OBSSR
Building 1, Room 326
1 Center Drive
Bethesda, MD 20892-0183
NormanAnderson@nih.gov

Andreassen, Carol
Westat
1550 Research Boulevard
Rockville, MD 20850
andreac1@westat.com

Angeles-Bautista, Adora 511
Teachers College
31 Essex Avenue
Maplewood, NJ 07040
Levindjeck@msn.com

Anger, Kent 579
Oregon Health Sciences University
CROET L606
3181 S.W. Sam Jackson Park Road
Portland, OR 97201

Answorth, Peggy 469
P.A.C.E. Head Start
710 Katie Avenue
Hattiesburg, MS 39401

Anthony, Bruno J. 560, 570
University of Maryland at Baltimore
Child and Adolescent Psychiatry
701 West Pratt Street
Baltimore, MD 21201
banthony@umpsy.ab.umd.edu

Armijo, Eduardo J. 136, 513
University of Washington
C-STARS
4725 30th Avenue, N.E.
Seattle, WA 98105
armijoed@u.washington.edu

Armstrong, Marcy 138

Atwater, Jane 128, 339
University of Kansas
Juniper Gardens Children's Project
650 Minnesota Avenue, 2nd Floor
Kansas City, KS 66101
janea@kuhub.cc.ukans.edu

Ayoub, Catherine C. 485, 582
Harvard Univesity Graduate School of Education
Larsen Hall, 7th Floor
Appian Way
Cambridge, MA 02138
ayoubca@hugse1.harvard.edu

Bachman, Heather J. 658
Loyola University of Chicago
Department of Psychology
6525 North Sheridan Road
Chicago, IL 60626
hbachma@orion.it.Luc.edu

Bae, Ji-Hi 222
University of Illinois
Human & Community Development
1105 West Nevada Street
Urbana, IL 61801

Baer, Judith 472
Rutgers University
536 George Street
New Brunswick, NJ 08903
jcbaer@rci.rutgers.edu

Bagnato, Stephen J. 393, 394
University of Pittsburgh
Children's Hospital
3705 Fifth Avenue
Pittsburgh, PA 15213
stephen_bagnato@popLar.chp.edu

Baim, Eric 630

Baker, Amy J.L. 620
Children's Village
Dobbs Ferry, NY 10522

Bales, Susan Nall 442, 451
Benton Foundation
1634 Eye Street, N.W.
11th Floor
Washington, DC 20006

Ball, Alison
Institute on Violence and Destructive Behavior
1265 University of Oregon
Eugene, OR 97403-1265

Banos-Rivas, Clarissa 531
University of Illinois at Chicago
2035 West Taylor Street
Chicago, IL 60612

Bardwell, Ann S.
Child Development Council
300 East Spring Street
Columbus, OH 43215

Barnard, Kathryn E. 137, 224, 296
University of Washington
School of Nursing
Box 357920
Room 212 South Building
Seattle, WA 98195-0001
kathyb@u.washington.edu

Barrera, Isaura 85, 95, 99, 101
University of New Mexico
Special Education Department
Hokona Hall 290
Albuquerque, NM 87131
ibarr@unm.edu

Barrueco, Sandra 478
University of Denver
Department of Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80208
sbarruec@nova.psy.du.edu

Bartholomew, Sheridan 384
1820 West Mulbery
Fort Collins, CO 80521

Battle, Renee
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

Bauer, Charles R. 602
University of Miami
Department of Pediatrics
P.O. Box 016960 (R-131)
Miami, FL 33101

Baugh, John 362
Stanford University
Department of Education and Linguistics
Stanford, CA 94305-1024
jbaugh@LeLand.stanford.edu

Beach, Betty A.
University of Maine at Farmington
Franklin Hall, 104 Main Street
Farmington, ME 04938
bbeach@maine.maine.edu

Becker-Klein, Rachel 657
Rutgers University
100 Joyce Kilmer Avenue
Piscataway, NJ 08854
racheL@psych.nyu.edu

Beckford-Ogunleye, Carla 622
Columbia University
Teachers College
525 West 120 Street
New York, NY 10027
cb5@coLumbia.edu

Begay, R. Cruz 508
Utah State University
Early Intervention Research Institute
Center for Persons With Disabilities
c/o Dr. Richard Roberts
Logan, UT 84322-6580

Beh, Elizabeth M. 636
Native American Head Start
R #4, Box 4642
Moscow, PA 18444

Behl, Diane D. 396
Utah State University
Early Intervention Research Institute
CPD Annex 1
Logan, UT 84322-6580
behLd@cpd2.usu.edu

Behl, Joan
New River Community Action, Inc.
Head Start Program
P.O. Box 570
Christiansburg, VA 24073
headstrt@swva.net

Behr, Debi 463
Westminster College
Preschool Lab
New Wilmington, PA 16172-0001

Bell, Lacy W., Jr.
Sampson County Head Start
P.O. Box 127
Clinton, NC 28328

Bell, Laura C. 491
Beginning with Children Foundation
900 3rd Avenue, N.E.
Suite 1801
New York, NY 10022
LbeLL@aoL.com

Bell, Lois A.
Administration for Children and Families
Technical Assistance and Coordination Branch
370 L'Enfant Promenade, S.W.
5th Floor
Washington, DC 20447
LbeLL@acf.dhhs.gov

Beltran, Marco 579
Oregon Child Development Coalition
9140 S.W. Pioneer Court
P.O. Box 2780
Wilsonville, OR 97070

Benedict, Mary 298
Johns Hopkins University
School of Hygiene and Public Health
624 North Broadway
Baltimore, MD 21205-1901
mbenedic@weLchLink.weLch jhu.edu

Bennett, Kathryn
McMaster University HSC-3V43D
Department of Clinical Epidemiology and Biostatics
Center for Studies of Children at Risk
1200 Main Street West
Hamilton, Ontario
Canada L8N 3Z5
kbennett@fhs.mcmaster.ca

Benson, Kelly C.
Trenton Head Start
222 East State Street
Trenton, NJ 08608

Bentley, Margaret 517
Johns Hopkins University
School of Hygiene and Public Health
615 North Wolfe Street, Room 2041
Baltimore, MD 21205

Berger, Gabrielle
Administration on Children, Youth and Families
Research Development and Evaluation Branch
330 C Street, S.W.
Switzer Building
Washington, DC 20447

Bergin, Christi Ann C. 544, 589, 590
University of Toledo
Educational Psychology Department
5002 C Gilham Hall
Toledo, OH 43606-3390
christi.bergin@utoLedo.edu

Berlin, Lisa J. 139
Teachers College, Columbia University
Center for Young Children and Families
525 West 120th Street
Box 39
New York, NY 10027
Ljb21@coLumbia.edu

Bernau, Bonnie
Very Special Arts (VSA)
1300 Connecticut Avenue, N.W.
Suite 700
Washington, DC 20036
bonnieb@vsarts.org

Bernholz, Farley
Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709
farLey@rti.org

Bernstein, Lawrence 119
ABT Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
Lawrence_bernstein@abtassoc.com

Berthoud, Cristiana M.E.
University of Taubate
Department of Psychology
Av. Tiradentes no 500 CEP
Taubate-SP
Brazil 12020-250
berthod@uoL.com.br

Bertness, Jolene
NCEMCH
2000 North 15th Street
Arlington, VA 22201
jbertness@ncemch.org

Better, Monique C. 242
University of Maryland at College Park
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742
mbetter@wam.umd.edu

Bhaerman, Robert
National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
bcbb@nasbe.org

Biever, Joan 529
Our Lady of the Lake University
San Antonio, TX 78207

Bigsby, Kathleen 639
Syracuse University
College for Human Development
201 Slocum Hall
Syracuse, NY 13244
kebigsby@maiLbox.syr.edu

Black, Kristin J.
Sheridan School District
Head Start
P.O. Box 1198
Englewood, CO 80150

Black, Maureen 251, 255, 517
University of Maryland School of Medicine
Department of Pediatrics
700 West Lombard Street
Baltimore, MD 21201

Blevins-Knabe, Belinda L. 604
University of Arkansas at Little Rock
Psychology Department
2801 South University
Little Rock, AR 72204
bLbLevins@uaLr.edu

Bloom, Barbara 292
P.O. Box 866
Petaluma, CA 94953

Blum, Holly 386, 387
Fairfax County Public Schools
3705 Crest Drive
Annandale, VA 22003

Bobadilla, Wendy 381
Fordham University
Psychology Department
Bronx, NY 10458

Bobo, Lynson Moore
United States Department of Education
600 Independence Avenue, S.W.
Portals Building, Room 4400
Washington, DC 20202
Lynson_bobo@ed.gov

Bolden, Myrna S.
Beaufort-Jasper Head Start
P.O. Box 2296
Beaufort, SC 29901

Bolig, Erika E.
Boysville of Michigan
8759 Clinton Macon Road
Clinton, MI 49236
eboLig@umich.edu

Boller, Kimberly 139, 670
Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
kboLLer@mathematica-mpr.com

Bond, James Terry 409
Families and Work Institute
2612 West 18th Street
Wilmington, DE 19806

Bonney, Ann 524
Connecticut Children's Health Project
999 Asylum Avenue
Hartford, CT 06105

Bordin, Judith 647
California State University at Chico
Child Development Program 220
9114 Troxel Road
Chico, CA 95928
jbordin@oavax.csuchico.edu

Boyce, Cheryl A.
National Institute of Mental Health
Administration on Children, Youth and Families
5600 Fishers Lane, Room 18C-17
Rockville, MD 20857
cboyce@nih.gov

Boyce, Glenna C. 393, 396
Utah State University
Early Intervention Research Institute
6580 University Boulevard
Logan, UT 84322-6580
gLenna@cpd2.usu.edu

Boyce, Lisa K. 134, 545
Utah State University
Family and Human Development
UMC 2905
North Logan, UT 84322-2905
sLLny@cc.usu.edu

Boyles, Carolyn D. 596
University of North Carolina at Greensboro
C-12 Park Building
P.O. Box 26170
Greensboro, NC 27402-6170
boyLesc@erickson.uncg.edu

Bradley, Robert H. 138, 139, 205, 210, 218, 219
University of Arkansas at Little Rock
Center for Research on Teaching and Learning
2801 South University Avenue
Little Rock, AR 72204
rhbradLey@uaLr.edu

Branch, Angela D. 386
8628 Spring Creek Court
Springfield, VA 22153

Branch, Jennifer B. 560, 570
Cold Spring Family Development
Head Start Therapeutic Nursery
4849 Pimlico Road
Baltimore, MD 21215

Brann, Edward
Centers for Disease Control, NCEH/BDDD
1600 Clifton Road, N.E., F-15
Atlanta, GA 30333
eab1@cdc.gov

Brasch, Beatty 666
Lincoln Action Program
1145 High Street
Lincoln, NE 68502

Bretherton, Inge 612
University of Wisconsin at Madison
Department of Child and Family Studies
1430 Linden Drive
Madison, WI 53706

Brezausek, Carl M. 172
Northwestern University
School of Education and Social Policy
2115 North Campus Drive
Evanston, IL 60208

Brizzi, Elsa N. 323, 633
LACOE Head Start Grantee
17315 Studebaker Road
Cerritos, CA 91104
Brizzi_ELsa@Lacoe.edu

Brondino, Michael J. 133
Medical University of South Carolina
Department of Psychiatry and Behavioral Sciences
171 Ashley Avenue
Annex III
Charleston, SC 29425-0742
brondimj@attrium.musc.edu

Bronson, Martha B. 145, 147
Boston College
School of Education
Campion Hall, 201B
Chestnut Hill, MA 02167
bronson@bcvms.bc.edu

Brookhart, Sarah
American Psychological Society
1010 Vermont Avenue, N.W.
Washington, DC 20005
sarahb@aps.washington.dc.us

Brooks-Gunn, Jeanne 139, 622
Teachers College, Columbia University
525 West 120th Street, Box 39
New York, NY 10027
jb224@coLumbia.edu

Brophy, Kathleen 512
University of Guelph
Department of Family Studies
Guelph, Ontario, Canada N1G 2W1

Brophy-Herb, Holly 129
725 Berkshire Lane
East Lansing, MI 48824-1030
hbrophy@piLot.msu.edu

Brotemarkle, Helen S. 577
University of Missouri at Kansas City
School of Education
615 East 52nd Street, Room 241
Kansas City, MO 64110
bobandheLen@worLdnet.att.net

Brown, Bernard 580
182 New Mark Esplanade
Rockville, MD 20850
berniebr@eroLs.com

Brown, Cheryl
WAGES Head Start
Children, Youth, and Families
601 East Royall Avenue
Goldsboro, NC 27534
cbwages@costoLnet.com

Brown, David L. 656
Texas Head Start Transition Project
6134 Big Bend Drive
Mesquite, TX 75150
DBrown8293@aoL.com

Brown, Elise
Every Child By Two
600 Maryland Avenue, S.W.
Suite 100W
Washington, DC 20024
Lbrown@ana.org

Brown, Gwendolyn Y.
Manatee County Head Start
1707 15th Street East
Bradenton, FL 34208

Brown, Mary Grace 128, 339

Brown, Wesley 510
East Tennessee State University
Box 70434
Johnson City, TN 37614

Brown, William H. 510
University of South Carolina
College of Education
Department of Educational Psychology
Wardlaw
Columbia, SC 29208
bbrown@ed.sc.edu

Brunner, Joan N. 592
Arizona State University
P.O. Box 87061
Tempe, AZ 85287-0611
j.brunner@asu.edu

Brush, Lorelei R.
Pelavin Research Center
1000 Thomas Jefferson Street, N.W.
Suite 400
Washington, DC 20007
Lbrush@air-dc.org

Bryant, Donna M. 152, 157, 256, 274
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
105 Smith Level Road, CB #8180
Chapel Hill, NC 27599-8180
bryant@unc.edu

Budgell, Richard
Health Canada
Childhood and Youth Division
Tunney's Pasture
Jeanne Mance Building, Room B948
Ottawa, Ontario
Canada K1A 1B5

Buente, Danielle
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
dbuente@eainet.com

Bullert, Dolores
NESD Head Start Program, Inc.
202 South Main Street, Suite 617
Aberdeen, SD 57401

Burchinal, Margaret R. 157, 256, 669
University of North Carolina
Frank Porter Graham Child Development Center
521 South Greensboro Street, Room 216
Carrboro, NC 27510
burchinaL@unc.edu

Burke, Sharon Ogden 528
Queen's University
School of Nursing
90 Barrie Street
Kingston, Ontario
Canada K7L 3N6
burkes@post.queensu.ca

Burton-Radzely, Lisa
Marco International, Inc.
11785 Beltsville Drive, Suite 300
Calverton, MD 20705
burton-radzeLy@macroint.com

Busby, Rosetta F. 492
ACAP Head Start
P.O. Box 6250
Arlington, VA 22206

Busch-Rossnagel, Nancy A. 380, 381
Fordham University
Keating Hall, Room 221
Bronx, NY 10458

Butera, Gretchen D.
West Virginia University
College of Human Resources and Education
P.O. Box 6122
Morgantown, WV 26505-6122
gbutera@wvu.edu

Butler, James 337
University of Pittsburgh
Graduate School of Public Health
230 Paran Hall
Pittsburgh, PA 15261

Cabrera, Connie 576
904 Pamela Drive
Mission, TX 78572

Cabrera, Natasha 139
National Institute of Child and Health Development
DBSB Center for Population Research
6100 Executive Boulevard
Room 8B13
Bethesda, MD 20892
cabreran@exchange.nih.gov

Cain, Johnnie
Portland State University
School of Extended Studies
Early Childhood Training Center
P.O. Box 1491
Portland, OR 97207
johnnie@ses.pdx.edu

Calderon, Rose 514
University of Washington, School of Medicine
Children's Hospital and Medical Center
CHMC, CH-13
4800 Sand Point Way, N.E.
Seattle, WA 98105-9907
rcaLde@chmc.org

Calejo, Maria 602
Mailman Center for Child Development
1601 N.W. 12th Avenue
Miami, FL 33136

Campbell, Frances A. 157, 172, 175, 251, 258, 650
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
105 Smith Level Road
CB #8180
Chapel Hill, NC 27599-8180
Frances_CampbeLL@unc.edu

Campbell, Wendell
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447

Campos, David 517
Roosevelt University
College of Education
430 South Michigan Avenue
Chicago, IL 60657

Canan, Maureen
University of Maryland University College
Head Start Research and Training
Boulevard at Adelphi Road
College Park, MD 20742-1630
canam@hrstc.umuc.edu

Canlas, Filipina
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
fcanLas@nhsa.org

Cardenas, Fred 529
Brackenridge/Highlands
237 West Travis
San Antonio, TX 78205

Carlson, Brenda J. 464
PACER Center
4826 Chicago Avenue South
Minneapolis, MN 55417
bcarLson@pacer.org

Carr, Victoria W. 395, 630
University of Cincinnati
Arlitt Child and Family Development Center
P.O. Box 210105
Cincinnati, OH 45221
victoria.carr@uc.edu

Carroll, Deborah E. 506, 609
University of North Carolina at Greensboro
Human Development and Family Studies
228 Stone Building
Greensboro, NC 27412
decarroL@hamLet.uncg.edu

Carta, Judith J. 128, 339
University of Kansas
Kansas E. C. Research Institute
Juniper Gardens Children's Project
650 Minnesota, Suite 3
Kansas City, KS 66101
carta@kuhub.cc.ukans.edu

Cartwright, Kelly B. 479
Christopher Newport University
Psychology Department
1 University Place
Newport News, VA 23606

Caruso, David A. 140, 141
University of Rhode Island
9 East Alumni Road
Kingston, RI 02881
caruso@uriacc.uri.edu

Carvell, Nell R. 598
Southern Methodist University
Learning Therapist Program
P.O. Box 750384
Dallas, TX 75275-0384
ncarveLL@maiL.smu.edu

Casey, Rita J.
Wayne State University
Merrill-Palmer Institute
71 East Ferry
Detroit, MI 48202
rcasey@sun.science.wayne.edu

Caskie, Grace I.L. 669
203-B Justice Street
Chapel Hill, NC 27516
caskie@maiL.fpg.unc.edu

Castellanos, William A.
EOC of San Luis Obisbo County
Head Start
1030 Southwood Drive
San Luis Obispo, CA 93401

Catelli, Linda A. 584
Dowling College
School of Education
Yonkers, NY 10701

Caughy, Margaret O'Brien 296, 297, 298, 583
Johns Hopkins University
Department of Maternal and Child Health
624 North Broadway
Baltimore, MD 21205
mcaughy@jhsph.edu

Ceglowski, Deborah A.
University of Minnesota
159 Pillsbury Drive, S.E.
Peik Hall
Minneapolis, MN 55455-0208
deber@tc.umn.edu

Celano, Marianne P. 386, 388
Emory University School of Medicine
Department of Psychiatry and Behavioral Sciences
Grady Memorial Hospital
Box 26064
80 Butler Street, S.E.
Atlanta, GA 30335
mceLano@emory.edu

Chaloner, W. Barry 638
San Juan College
844 East 4th Avenue
Durango, CO 81301
bca@frontier.net

Chance, Gwendolyn D.
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
gchance@acf.dhhs.gov

Charlot-Swilley, Dominique 560
University of Maryland
Department of Psychiatry
701 West Pratt Street
Baltimore, MD 21203

Chau, Puisana 642
Syracuse University
202 Slocum Hall
Syracuse, NY 13244-1250

Cherner, Stacie S. 536
SRI International
333 Ravenswood Avenue
Menlo Park, CA 94025
scherner@unix.sri.com

Childs, Stephanie 143
South Philadelphia High School
Philadelphia Head Start Learning Center
Broad and Snyder Avenue, Room 203
Philadelphia, PA 19148

Churchill, Susan L. 612
University of Georgia
Program on Human Development and Disability
River's Crossing
Athens, GA 30602
susanc@arches.uga.edu

Ciancio, Dennis 659
1247 North Notre Dame Avenue
South Bend, IN 46617
dsciancio@emaiL.msn.com

Clark, Beryl 620
Staten Island Mental Health Services Head Start
44 Dongan Hill Avenue
Staten Island, NY 10306

Clark, Cheryl
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
ccLark@eainet.com

Clark, Patricia 502
Ball State University
Teachers College
Room 216
Muncie, IN 47306
00pacLark@bsu.edu

Clawson, Mellisa A. 639, 641, 642
Syracuse University
College for Human Development
202 Slocum Hall
Syracuse, NY 13244-1250
macLawso@maiLbox.syr.edu

Clifford, Richard M. 552
University of North Carolina
Frank Porter Graham Child Development Center
300 NationsBank Plaza
137 East Franklin Street, CB 8040
Chapel Hill, NC 27514
dickcLifford@unc.edu

Clifton, Rachel K.
University of Massachusetts
Department of Psychology
Tobin Hall
Box 37710
Amherst, MA 01003-7710
racheL@psych.umass.edu

Clubb, Richard 138
UAP of Arkansas at Monticello
AUM - Division of Social Services
Monticello, AR 71656
cLubb@uamont.edu

Cluett, Sandra 550
University of Alabama at Birmingham
1720 7th Avenue South, SC 331
Birmingham, AL 35294
scLuett@civmaiL.circ.uab.edu

Coates, Deborah L. 79, 82, 84, 411, 418
City University of New York
Program in Social and Personality Psychology
33 West 42nd Street
New York, NY 10036
vietcoat@ix.netcom.com

Cochran, Kathleen Mayo 485
Columbia University
Teachers College
Box 53 - ICCCR
525 West 120 Street
New York, NY 10027
cochrank@aoL.com

Cochran, Moncrieff M. 467, 482
Cornell University
G27 MVR Hall
Ithaca, NY 14853
mmc6@corneLL.edu

Coelho, Maria Renata
University of Taubate
Av. Tiradentes no 500 CEP
Taubate-SP
Brazil 12020-250
berthod@uoL.com.br

Cohen, Linda
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
Lcohen@acf.dhhs.gov

Cohen, Meredith 664
University of Pittsburgh
Department of Psychology in Education
5C01 Forbes Quad
Pittsburgh, PA 15260-7478

Cohen, Saundy
Belknap-Merrimack Head Start
P.O. Box 1016
Concord, NH 03301
cohens1234@aoL.com

Colbert, Karen 162
Iowa State University
Human Development and Family Studies
101 Child Development Building
Ames, IA 50011-1030

Coll, Cynthia Garcia 43, 47, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 254, 332
Brown University
Education Department
P.O. Box 1938
Providence, RI 02912-1938
cgc@brownvm.brown.edu

Collins, Ann M. 190, 191, 192, 193, 194, 196, 197, 202, 203
Columbia University School of Public Health
National Center for Children in Poverty
154 Haven Avenue
New York, NY 10032
ac261@coLumbia.edu

Collins, Tracy
Harvard Graduate School of Education
School of Education
Appian Way
Cambridge, MA 02138
coLLintr@hugse1.harvard.edu

Connell, David B. 153, 154
ABT Associates
55 Wheeler Street
Cambridge, MA 01720
dave_conneLL@abt.assoc.com

Conrad, Katie F. 160, 524
Connecticut Children's Health Project
999 Asylum Avenue, Suite 200
Hartford, CT 06105

Conroy, Maureen A. 510
University of Florida/College of Education
Department of Special Education
Box 117050
Gainesville, FL 32611
mconroy@coe.ufL.edu

Cook, Gina A. 545
Utah State University
Department of Family and Human Development
Hyde Park, UT 84318
sLfzq@cc.usu.edu

Coolahan, Kathleen Coyle 143, 625, 627
Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
kcooLahan@mathematica-mpr.com

Cooney, J.P.
DHHS-ASPE-CYP
200 Independence Avenue
Washington, DC 20201
jcooney@osaspc.gov

Cooper, Rachel J. 172
Northwestern University
School of Education and Social Policy
2115 North Campus Drive
Evanston, IL 60208

Cooper, Susan G. 495
Southeastern Louisiana University
Family Studies and Educational Leadership
Box 341
Hammond, LA 70402
scooper@seLu.edu

Coover, Lenore 531
U.I.C.-Pediatric Case Management
8833 Southmoor
Highland, IN 46322
Lcooverrn@aoL.com

Corbin, Yalonda 538
ICHAP / MHRA
40 Worth Street, Room 728
New York, NY 10013

Cordray, David 350, 351, 352, 353, 354, 355, 357, 358, 359, 360, 361
Vanderbilt University
1208 18th Avenue South
Room 158
Nashville, TN 37212

Correll, Donnesha Y.
United States General Accounting Office
441 G Street, N.W., Room 5944
Washington, DC 20548
correLd@hehs.gao.gov

Costa, Pamela
San Juan Unified School District
Head Start Program
5309 Kenneth Avenue
Carmichael, CA 95608

Cox, Mary-Lorraine 475
14231 Bedding Field Way
Centreville, VA 22020

Craig, Lesley A.
Vanderbilt University
Special Education
P.O. Box 328, Peabody College
Nashville, TN 37203
LesLey.a.craig@vanderbiLt.edu

Creasey, Gary 558
Illinois State University
Psychology Department
Normal, IL 61790-4620

Crompton, Dwayne A. 409
KCMC Child Development Corporation
Administration
2104 East 18th Street
Kansas City, KS 64127

Cross, Jacqueline
Anoka County Community Action Program Head Start
9574 Foley Boulevard
Coon Rapids, MN 55433

Crouch, Myra G.
Office for Children
Head Start Program
12011 Government Center Parkway, Suite 930
Fairfax, VA 22035

Crowley, Maureen P. 599
Wellesley College
Center for Research on Women
828 Washington Street
Wellesley, MA 02181
mcrowLey@weLLesLey.edu

Cruz, Carmen
New York Foundling
P.O. Box 191274
San Juan, PR 00919-1274

Cryer, Debby 552
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
300 NationsBank Plaza
Chapel Hill, NC 27514

Culp, Anne McDonald 556, 566
University of Alabama
College of Human Environmental Sciences
Human Development and Family Studies
206 Doster Hall
Box 870158
Tuscaloosa, AL 35487-0158
acuLp@ches.va.edu

Culp, Rex E. 556, 566
University of Alabama
Human Development and Family Studies
Box 870158
Tuscaloosa, AL 35487-0158
rexcuLp@ches.va.edu

Cunningham, Gayle
JCCEO
300 8th Avenue West
Birmingham, AL 35204
gcjcceo@aoL.com

Curtis, Barbara
Bernard Van Foundation
10205 Kings Arm Tavern
Ellicott City, MD 21042
bjwaterscurtis@worLdnet.att.net

Curtis, Lynn 425, 426, 435, 436, 437, 438, 439, 440, 441
The Milton S. Eisenhower Foundation and Corporation for What Works
1660 L Street, N.W.
Suite 200
Washington, DC 20036
mseisenhower@msn.com

Curtis, Susan 577
University of Missouri at Kansas City
School of Education
615 East 52nd Street, Room 241
Kansas City, MO 64110

Cuttler, Noah
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

D'Elio, Mary Ann 153, 155
The CDM Group, Inc.
5530 Wisconsin Avenue
Suite 1600
Chevy Chase, MD 20815
mdeLio@cdmgroup.com

Dabrow, Sharon 388, 595
University of South Florida
General Pediatrics
17 Davis Boulevard, Suite 308
Tampa, FL 33606

Dalley, Dana S.
Head Start
P.O. Box 614
Ogunquit, ME 03907

Dane, Barbara T. 632
New York University
Ehrenkranz School of Social Work
1 Washington Square North
New York, NY 10003-6654
dane@is3.nyu.edu

Daniels, Darlene
University of Maryland University College
Head Start Resource and Training Center
7812 Karla Lane
Fort Washington, MD 20744

Danziger, Sheldon 57, 69, 70
University of Michigan
School of Social Work
540 East Liberty Street, Suite 202
Ann Arbor, MI 48104-2210
sheLdond@psc.Lsa.umich.edu

Darling, Cathia 322
Miami-Dade County Public School
1500 Biscayne Boulevard, Room 335
Miami, FL 33142
ddarLing1@compuserve.com

Davis, Jacqueline
Development Associates, Inc.
1475 North Broadway, Suite 200
Walnut Creek, CA 94596
jdavis@pacbeLL.net

Davis-Wellington, Beth 537
University of Notre Dame
Department of Psychology
Notre Dame, IN 46556

Day, Jeanne D. 559
University of Notre Dame
Department of Psychology
51811 Village Parkway
Granger, IN 46530
jeanne.d.day.1@nd.edu

DeGraw, Donna 555
Seton Hall University
PPFT
400 South Orange Avenue
South Orange, NJ 07079

DeLuca, Mary C. 671
Community Action Agency
1214 Greenwood Avenue
Jackson, MI 49203
region2caa@dmci.net

Dennis, Sheila 560, 570
Cold Spring Head Start
P.O. Box 2565
Baltimore, MD 21215

Denton, David 30, 39
Southern Regional Education Board
592 Tenth Street, N.W.
Atlanta, GA 30318-5790
david.denton@sreb.org

Denton, Kristin L. 600
National Center for Education Statistics
555 New Jersey Avenue, N.W.
Room 417B
Washington, DC 20208-5651
kristin_denton_at_essi-maiL@air-dc.org

deVries, Mary 608
University of Michigan
610 East University
4216 SEB
Ann Arbor, MI 48109-1259
maryde@umich.edu

Dewarics, Charles
Report on Preschool Programs
719 Timber Branch Parkway
Alexandria, VA 22302
cdewarics@compuserve.com

Diaz, Laura M. 599, 615
University of Denver
Clinical Psychology
2155 South Race Street
Frontier Hall
Denver, CO 80208
Ldiaz@nova.psy.du.edu

Dickerson-Waters, Anise 143
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104-6216

Dickinson, David K. 41
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02158
ddickins@edc.org

Dickinson, Lynda J. 140
Child, Inc.
Head Start Program
1642 West Shore Road
Warwick, RI 02889

Dighe, Judith
Head Start Montgomery County Public Schools
4910 Macon Road
Rockville, MD 20852

Dillon, Amy 160
1344 Spring Valley Drive
Huntington, WV 25701

Dirks, Jane 338
324 Pitt Street
Pittsburgh, PA 15221
dirks@sis.pitt.edu

Divine, Pia
Administration on Children, Youth and Families
Child Care Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
Pdivine@acf.dhhs.gov

Doan, Henry M. 153
Administration on Children, Youth and Families
330 C Street, S.W.
Switzer Building 2121
Washington, DC 20447
hedoan@acf.dhhs.gov

Dobbins, Dionne R. 605, 606
University of North Carolina at Chapel Hill
School of Education
108 Peabody Hall
Campus Box #3500
Chapel Hill, NC 27599
ddobbins@emaiL.unc.edu

Dodgen, Dan
American Psychological Association
750 1st Street, N.E.
Washington, DC 20008
ddodgen@apa.org

Doerr, Anne M.
Lycoming-Clinton Head Start
Pennsylvania Head Start/ Adminstrators Association
P.O. Box 3568
Williamsport, PA 17701
amdoerr@csrLink.net

Doggett, Libby
United States Department of Education
MES 3080
330 C Street, S.W.
Washington, DC 20202
eLizabeth_doggett@ed.gov

Doherty, Nicole 630

Dollar-Brashears, Barbara
University of Maryland University College
Head Start Resource and Training Center
1353 Moyer Road
Annapolis, MD 21403
doLLb@hsrtc.umuc.edu

Domitrovich, Celene E. 560, 570
Penn State Prevention Research Center
110 Henderson Building
University Park, PA 16802
cxd130@psu.edu

Domond, Virginia
Newark Preschool Council
114 Alpine Trail
Sparta, NJ 07871

Donahue, Caroline 538

Donahue, Paul J. 573
The Center for Preventive Psychiatry
360 Mamaroneck Avenue
White Plains, NY 10605
pjdon@earthLink.com

Dool, Eric 630
University of Cincinnati
College of Education
P.O. Box 210002
Cincinnati, OH 45221

Dougherty, Nancy J. 520
Albert Einstein College of Medicine
Dentistry/Pediatrics
Rose F. Kennedy Center
1410 Pelham Parkway South
Bronx, NY 10461
munchko@aoL.com

Doyle, John
Administration for Children and Families
370 L'Enfant Promenade
Washington, DC 20447

Dradgeny, Enid 408

Drapeaux, Jane 160
SCCD, Inc.
Wagner Street
P.O. Box 1020
Wagner, SD 57380

Duffy, Farrah F. 561
Johns Hopkins University
Department of Mental Health
School of Public Health
624 North Broadway, 8th Floor
Baltimore, MD 21205
fduffy@phir.jhsph.edu

Dunham, Claire
The Ounce of Prevention Fund
122 South Michigan, Suite 2050
Chicago, IL 60603
cd122@enteract.com

East, Alicia 660
University of California at Irvine
c/o Professor Wendy Goldberg
3340 Social Ecology Irvine II
Irvine, CA 92697-7085

Eisenberg, Laurie 461
The House Ear Institute
2100 West 3rd Street
Los Angeles, CA 90057

Emde, Robert N. 125, 126, 336, 549
University of Colorado Health Sciences Center
Program for Early Development Studies
4200 East 9th Avenue, Box C268-69
Denver, CO 80262
bob.emde@uchsc.edu

Emihovich, Catherine 525
State University of New York at Buffalo
BRIET 381 Baldy Hall
Buffalo, NY 14260-1000
cemihovi@acsu.buffaLo.edu

Engebretson, Tammy 588
CFDC
3025 Parker Street
Omaha, NE 68111

Epps, Susan 503
Dupont Hospital for Children
P.O. Box 269
Wilmington, DE 19899

Epps, Willie J. 315, 316, 323, 325, 326, 327, 328
Southern Illinois University at Edwardsville
East St. Louis Center
411 East Broadway
East St. Louis, IL 62201
wepps@siue.edu

Epstein, Ann 145, 494, 662
University of Kentucky
212 K Taylor Education Building
Lexington, KY 40506
amerst0@pop.uky.edu

Erikson, Joanna 542
115 Blake Road
Hamden, CT 06517
jme9@pantheon.yaLe.edu

Erkut, Sumru 254
Wellesley College
Center for Research of Women
106 Central Street
Wellesley, MA 02481

Erler, Lynne
Dakota Technologies Corporation
Government Services Division
5200 Ellicott Court
Centreville, VA 22020
Lynne@dakota-tech.com

Espinosa, Linda M. 492
University of Missouri at Columbia
College of Education
301-D Townsend Hall
Columbia, MO 65211
ciLme@showme.missouri.edu

Esposito, Cynthia A. 172, 173
Rutgers University
SSW/CSCD
Livingston Campus
Building 4161, Room 236
100 Joyce Kilmer Road
Piscataway, NJ 08855
cindyesp@rci.rutgers.edu

Evans, David W. 510
Bucknell University
Psychology Department
Lewisberg, PA 17837
dweps@uno.edu

Evans, Jerryneta I.
Dothan City Schools
Head Start
500 Dusy Street
Dothan, AL 36301

Fagan, Jay S. 220, 221
Temple University
School of Social Administration
Ritter Hall Annex, 5th Floor
13th Street and Cecil B. Moore Avenue
Philadelphia, PA 19122
jfagan@nimbus.ocis.tempLe.edu

Faldowski, Richard A. 133
Medical University of South Carolina
Department of Psychiatry
850 MUSC Complex-Psychology Annex I
Charleston, SC 29425-0742
faLdowra@musc.edu

Fantuzzo, John W. 72, 77, 79, 80, 82, 84, 140, 143, 437, 438, 439, 440, 553, 627
University of Pennsylvania
Graduate School of Education/PED
3700 Walnut Street
Philadelphia, PA 19104
johnf@gse.upenn.edu

Farran, Dale C. 497, 596
Vanderbilt University-George Peabody College
Department of Teaching and Learning
Box 330 GPC
Room 360
Nashville, TN 37203
farrandc@ctrvax.vanderbiLt.edu

Farrar, Anne R. 555
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079

Farver, Jo Ann M. 571
University of Southern California
Department of Psychology
SGM 501
Los Angeles, CA 90089-1061
farver@rcf.usc.edu

Feil, Edward G. 242, 244, 386, 389
Institute on Violence and Destructive Behavior
1265 University of Oregon
Eugene, OR 97403-1265
edf@ori.org

Feinberg, Mindy
Ridgewood Bushwick Senior Citizens Council
217 Wyckoff Avenue
Brooklyn, NY 11237
mrf27@coLumbia.edu

Fendall, Paula 632
203 Milwood Avenue
Brooklyn, NY 11225

Fenichel, Emily S.
Zero to Three
734 15th Street, N.W., 10th Floor
Washington, DC 20005
e.fenicheL@zerotothree.org

Ferro, Jolenea B. 499
University of South Florida
13301 North Bruce B. Downs Boulevard
Tampa, FL 33612
ferro@haL.fmhi.usf.edu

Fetter, Anne L. 147
P.O. Box 370
Byfield, MA 01922

Fholer, Marie 609
502 East Brown Street
Mebare, NC 27302

Fields, Jacqueline P. 254
Wellesley College
Center for Research of Women
106 Central Street
Wellesley, MA 02481

Fillmore, William S., Jr. 205, 207, 218
Pinellas County Head Start
Child Development and Family Services Head Start
6698 68th Avenue North, Suite D
Pinellas Park, FL 33781

Fine, Mark A. 129, 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65211
hdfsfine@showme.missouri.edu

Finn, Eric 568
Columbia University
Teachers College
525 West 120th Street
New York, NY 10027

Fischel, Janet E. 655
State University of New York at Stony Brook
Department of Pediatrics
Stony Brook, NY 11794-8111
jfischeL@epo.som.sunsyb.edu

Fisher, Celia B. 411, 421
Fordham University
Department of Psychology, Dealy Hall
441 East Fordham Road
New York, NY 10021
fisher@murray.fordham.edu

FitzGerald, Charlanne 652, 654
University of Wisconsin
Center for Health Policy and Program Evaluation
433 West Washington Avenue, Suite 500
Madison, WI 53703

FitzGerald, David D. 537
Durham Community Guidance Clinic
Duke University Medical Center
P.O. Box 2906
Durham, NC 27710

Fitzgerald, Hiram E. 72, 80, 82, 129, 139
The World Association for Infant Mental Health
Michigan State University
6 Kellogg Center
East Lansing, MI 48824-1022
fitzger9@piLot.msu.edu

Fleitz, Rosemarie 589
SVMC Family Care Center
2213 Franklin Avenue
Toledo, OH 43620

Flores, Alfredo R.
Texas Tech University
Institute for Child and Family Studies
P.O. Box 41162
Lubbock, TX 79409

Flores, Lawrence G.
Development Associates, Inc.
1475 North Broadway, Suite 200
Walnut Creek, CA 94596
LfLores@pacbeLL.net

Flores-Fahs, Pamela 570
University of Maryland at Baltimore
Child and Adolescent Psychiatry
701 West Pratt Street
Baltimore, MD 21201

Florian, Judy E. 145, 662
High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, MI 48198-2898
judyf@highscope.org

Ford, Dell
Head Start Collaboration
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447

Ford, Rich D.
House Committee on Education and Workforce
230 Ford HOB
Washington, DC 20515
richard.ford@maiL.house.com

Fore, Carolyn Vass 566
Oklahoma State University
FRCD
Stillwater, OK 74078

Forness, Steven R. 242
University of California at
Los Angeles
Neuropsychiatric Hospital
760 Westwood Plaza
Los Angeles, CA 90024

Forsyth, Ouida
Head Start
206 Woodbluff Drive
Lafayette, LA 70503
pmLandry@Lft.kiz.La.us.

Foster, Edward Michael 594
Georgia State University
School of Policy Studies-PAVS
University Plaza
Atlanta, GA 30303-3083
pademf@panther.gsu.edu

Foster, Laura Gutermuth 560, 570
University of Maryland at Baltimore
Child and Adolescent Psychiatry
701 West Pratt Street
Baltimore, MD 21201
LFoster@umpsy.ab.umd.edu

Foster, Martha
Georgia State University
426A Sparks Hall
University Plaza
Atlanta, GA 30303-3083

Foster, Roger
Avance, Inc.
301 South Frio, Suite 380
San Antonio, TX 78207

Fowler, Susan A. 168
61 Children's Research Center
51 Gerty Drive
Champaign, IL 61820
s-fowLer@uiuc.edu

Fox, Theresa C. 661
Rutgers University
144 Estates Boulevard,
Apartment 114
Hamilton, NJ 08610
Lkzroia@prodigy.com

Fox-Hays, Heather
YWCA-Minneapolis
3000 West River Parkway, #104
Minneapolis, MN 55404

Franchi, Dina 530
Families in Transition
Beth Israel Medical Center
295 First Avenue
New York, NY 10003

Franco, Margaret 584
CUNY/Queens College
65-30 Kissence Boulevard
Flushing, NY 11367

Frank, Adrienne 637
Child Development Resources
P.O. Box 280
Norge, VA 23127-0280
adrienne-gary@eroLs.com

Franze, Sarah E. 329
Georgia State University
Adult Literacy Center
University Plaza
Atlanta, GA 30303-3083
gs02sef@panther.gsu.edu

Frasier, Nina B. 564
University of Denver
Department of Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80210

Frassetto, Sandra J. 665
Michigan State University
Department of Psychology
135 Snyder Hall
East Lansing, MI 48824
frassett@piLot.msu.edu

Freel, Karen A. 614
The Ounce of Prevention Fund
122 South Michigan, Suite 2050
Chicago, IL 60603

Freeman, Gwen M.
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

French, Tearesa
Caroline City Family Support Center
100 North 6th Street
Denton, MD 21629

Freund, Maxine B. 667
The George Washington University
School of Education and
Human Development
2134 G Street, N.W.
Washington, DC 20052
mfreund@gwisz.circ.gwu.edu

Friedman, Jennifer
Office of Management and Budget
725 17th Street, N.W.
Room 8222
Washington, DC 20503
friedman-j@a1.eop.gov

Friedman, Kimberly 336, 338
Harvard Family Research Project
53 Chapin Road
South Newfane, VT 05351-7901
kfriedres@juno.com

Friedman-Lipetz, Inez C.
United Cerebral Palsy Association
422 Chapel Road
Elkins Park, PA 19027

Friesen, Barbara J.
Portland State University
P.O. Box 751
Portland, OR 97207

Fritz, Janet J. 382
Colorado State University
Department of Human
Development and Family Studies
Fort Collins, CO 80523-1570

Frohlich, Margaret "Peggy"
University of Denver
Department of Psychology
2155 South Race Street, Frontier Hall
Denver, CO 80210
mfrohLic@du.edu

Fromboluti, Carol Sue 488
Office of Education, Research, and
Improvement
National Institute on Childhood
Dev. and Education
555 New Jersey Avenue, N.W.
Washington, DC 20015
caroL_fromboLuti@ed.gov

Frost, Mary W. 490
CTED
906 Columbia Street, S.W.
P.O. Box 48300
Olympia, WA 98504-8300
maryf@cted.wa.gov

Fuddy, Loretta J.
State Department of Health
Maternal and Child Health Branch
741-A Sunset Avenue, #203
Honolulu, HI 96816
Lfuddy@hawaii.edu

Funderburke, Michelle 138
Creighton University
School of Nursing
2500 California Plaza
Omaha, NE 68178

Furlong, Beth 532
Creighton University
School of Nursing
2500 California Plaza
Omaha, NE 68178
bfurLong@creighton.edu

Furstenberg, Frank F., Jr. 594
University of Pennsylvania
Department of Sociology
3718 Locust Walk
Philadelphia, PA 19104-6299

Gadsden, Vivian L. 205, 214, 220
University of Pennsylvania
National Center on Fathers and Families
3700 Walnut Street, Box 58
Philadelphia, PA 19104-6216
gadsden@Literacy.upenn.edu

Gal, Laura Williams 610
Witmer, Karp, Warner, and Thuotte
28 State Street
22nd Floor
Boston, MA 02109

Galper, Alice R. 158, 600
University of Maryland
College of Education
3304 Benjamin Building
College Park, MD 20742-1131
hagaLper@pipeLine.com

Gant, Sandra K.
North Carolina Central University
127 Hazel Drive
Burlington, NC 27217

Garcia, Mercedes 571
University of Southern California
714 West 27th Street
Los Angeles, CA 90007
m.garcia@rcf.usc.edu

Garcia-Tunon, Aurora
New York University
Resource Access Project (Region II)
239 Greene Street, Room 200
New York, NY 10003

Garfield, Cleona 561
Umoja Head Start Academy
Harlem Park Community Center
1500 Harlem Avenue
Baltimore, MD 21217

Garrett, Barbara 72, 74
Berkeley Head Start Program
2009 10th Street
Berkeley, CA 94710-2119

Garrett, Kimberly N. 492
Route 2, Box 488
Nathalie, VA 24577

Gassaway, Jeanette M. 172, 174, 665
Michigan State University
Department of Psychology
135 Synder Hall
East Lansing, MI 48824
gassawa1@piLot.msu.edu

Gavin, Karen M. 498
University of Miami
Department of Psychology
Box 249229
Coral Gables, FL 33124-0721
kmgavin@usa.net

Gavin, Lorrie 517
Johns Hopkins University School of Hygiene
Department of International Health
615 North Wolfe Street, Room 2041
Baltimore, MD 21201
Lorgavin@aoL.com

Gebben, Marcia R.
Spectrum Health/Butterworth
100 Michigan, N.E.
MC-94
Grand Rapids, MI 49503

Geller, Susan Rose 486
Virginia Commonwealth University
Virginia Institute for Developmental Disabilities
P.O. Box 29070
Richmond, VA 23242
sgeLLer@atLas.vcu.edu

Genevro, Janice L. 298
Johns Hopkins School of Public Health
624 North Broadway
Baltimore, MD 21205

Gensler, Taube
Southwest Human Development
202 East Earll Drive, Suite 140
Phoenix, AZ 85012
tgensLer@swhd.org

George, Lee 468
P.O. Box 570
Christianburg, VA 24073

Gerlach, Jacquelyn 528
Queen's University
School of Nursing
90 Barie Street
Kingston, Ontario, Canada
K7L 3N6

Gerlach-Downie, Suzanne G. 342
SRI International
Health and Social Policy Division
333 Ravenswood Avenue, Box 131
Menlo Park, CA 94024-3493
suzLgd@unix.sri.com

Gestrich, Susan 393, 394
COTRAIC Head Start
201 Rochelle Street
Pittsburgh, PA 15210

Ghahary, Nouriman 555
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079
nashenas@msn.com

Ghelfi, Linda
United States Department of Agriculture
Economic Research Service
1800 M Street, N.W.
Room 2081
Washington, DC 20036-5831
LgheLfi@econ.ag.gov

Gibbons, Cynthia L. 129, 139
Michigan State University
College of Nursing
A203 Life Sciences
East Lansing, MI 48824
cgibbons@msu.edu

Gilkerson, Linda 614
Erikson Institute
420 North Wabash Street
Chicago, IL 60610

Gill, Sukhdeep
The Pennsylvania State University
1164 Smithfield Street
State College, PA 16801
sgiLL@psu.edu

Gilman, Elizabeth
Yale University
Department of Psychology
2 Hillhouse Avenue
New Haven, CT 06520
eLizabeth.giLman@yaLe.edu

Golas, Julianna C. 140, 141
University of Rhode Island
Department of Human Development
Transition Center
Kingston, RI 02881
jgoL@uriacc.uri.edu

Goldberg, Wendy A. 660
University of California at Irvine
Department of Psychology and Social Behavior
3340 Social Ecology II
Irvine, CA 92697-7085
wagoLdbe@uci.edu

Golden, Olivia A.
Administration for Children and Families
370 L'Enfant Promenade
Washington, DC 20447

Goldman, Jane 611, 623
University of Connecticut
School of Family Studies
348 Mansfield Road, U-58
Stors, CT 06269-2058
goLdman@uconnvm.uconn.edu

Goldman, Lisa M. 586
1806 Calibre Woods Drive
Atlanta, GA 30329
LmgoLdman@mindspring.com

Goldsmith, Nancy A. 600
Montgomery County Public Schools
Transition/Early Childhood Education Services
4910 Macon Road
Rockville, MD 20852-2228

Goldstein, Arlene H.
Aspen Systems Corporation
2277 Research Boulevard
Rockville, MD 20850
agoLdstein@aspensys.com

Goldstein, Brian 470
Temple University
Communication Sciences
109 Weiss Hall
Philadelphia, PA 19122
goLdstba@nimbus.tempLe.edu

Golly, Annemieke 247
200 North Monroe
Eugene, OR 97402

Gomby, Deanna
The David and Lucille Packard Foundation
Center for the Future of Children
300 2nd Street, Suite 200
Los Altos, CA 94022
d.gomby@packfound.org

Gonzales, Richard F. 72, 74, 81, 82, 153, 393
ACS/Head Start
30 Main Street
Sweeney Building, 10th Floor
Brooklyn, NY 11201

Good, Roland 386, 389
University of Oregon
School of Psychology
Eugene, OR 97403

Goodson, Barbara Dillon 119, 120
ABT Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138
barbara_goodson@abtassoc.com

Goosney, Janet 476
Memorial University
Department of Education
St. John's, Newfoundland
Canada A1B 3X8
janetg@morgan.ucs.mun.ca

Gordon, Amy 563
Child Welfare League of America
7013 Fordham Court, #2
College Park, MD 20740
agordon@cwLa.org

Gozali-Lee, Edith M. 474
Wilder Research Center
1295 Bandana Boulevard North
Suite 210
St. Paul, MN 55108
emg@wiLder.org

Graber, Julia 622
Teachers College, Columbia University
Adolescent Study Program
525 West 120th Street, Box 39
New York, NY 10027

Gracey, Patricia J. 319
Northern Panhandle Head Start, Inc.
51 16th Street, 4th Floor
Wheeling, WV 26003
nphs@1st.net

Graham, Mimi
Florida State University
Center of Prevention and Early Intervention Policy
1339 East Lafayette Street
Tallahassee, FL 32301

Grant, Christy
Tennessee State University
330 10th Avenue North
Box 141
Nashville, TN 37203

Grant, Linda 595
Hughes Spaulding Children's Hospital
Health Promotion
35 Butler Street
Atlanta, GA 30335

Graves, Janet K. 532
Creighton University School of Nursing
Parent Child Nursing
2500 California Plaza
Omaha, NE 68178
jgraves@creighton.edu

Gray, Dennis
Administration on Children, Youth and Families
330 C Street, S.W.
Switzer Building
Washington, DC 20447
grays@eroLs.com

Gray, Fabienne Lee 510
University of New Orleans
Lakefront Building, GP-2001
New Orleans, LA 70148

Gray, Harriet H.
CLAS Early Childhood Research Institute
The Council for Exceptional Children
1920 Association Drive
Reston, VA 20191-1589
harrietg@cec.sped.org

Green, Beth L. 132, 337, 340, 343, 347, 348, 349
Portland State University
Department of Psychology
317 Cramer Hall
Portland, OR 97207
greenb@pdx.edu

Green, Melinda W.
National Black Child Development Institute
1023 15th Street, N.W.
Suite 600
Washington, DC 20005
mgreen@nbcdi.org

Greene, Sarah M. 30
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
sgreene@nationaL.nhsa.org

Greenfield, Daryl B. 72, 76, 79, 350, 351, 355, 357, 359, 498
University of Miami
Department of Psychology
Box 249229
Coral Gables, FL 33124-0721
dgreen@peds.med.miami.edu

Greenstein, Barbara 139
20 West 80th Street, #B
New York, NY 10024-3604

Gregory, Lenora S.
Episcopal Children's Services, Inc.
4070 Boulevard Center Drive, Suite 200
Jacksonville, FL 32207

Griffin, James 488
Office of Education, Research, and Improvement
United States Department of Education
555 New Jersey Avenue, N.W.
Washington, DC 20208
james_griffin@ed.gov

Grimmer, Scharman T. 641
Syracuse University
202 Slocum Hall
Syracuse, NY 13244-1250
mggrimme@maiLbox.syr.edu

Grimstad, Jane A. 490
NWREL
101 SW Main Street, Suite 500
Portland, OR 97201
grimstaj@nwreL.org

Grosbard, Ronnie
Peaceful Kids/Safe Kids
260 West 72nd Street
Apartment 4D
New York City, NY 10023

Gross, Ruth
CEDA of Cook County, Inc.
208 South LaSalle Street
Chicago, IL 60604

Groves, Melissa M.
University of Tennessee
Department of Child and Family Studies
115 Jesse Harris Building
Knoxville, TN 37966-1900
mgroves1@utk.edu

Guyer, Bernard 296, 297
Johns Hopkins School of Public Health
Department of Maternal and Child Health
624 North Broadway, Room 182
Baltimore, MD 21205
bguyer@jhsph.edu

Hagen, John W. 4, 21, 57, 68, 69, 71, 350, 357, 411, 424
University of Michigan
Society for Research in Child Development
SRCD-1070, N.E.
300 North Ingalls Building
Ann Arbor, MI 48109-0406
jwhagen@umich.edu

Hains, Ann Higgins 166, 168
University of Wisconsin at Milwaukee
School of Education
2400 East Hartford Avenue, Ender's Hall
Room 697
Milwaukee, WI 53211
annhains@csd.uwm.edu

Hairston, Creasie Finney 292
University of Illinois
Jane Adams College of Social Work
1040 West Harrison Street, Room 4010
Chicago, IL 60607
cfh@uic.edu

Hamberg, Jill M.
New York University
Head Start Q.I.C.
726 Broadway, 5th Floor
New York, NY 10003
jh21@is2.nyu.edu

Hamburg, Beatrix A.
William T. Grant Foundation
1140 Fifth Avenue
New York, NY 10128

Hamer, Lynne 590
The University of Toledo
Educational Psychology, Research, & Social Found.
Toledo, OH 43606

Hamilton, Claire E. 139
University of Georgia
Elementary Education
427 Aderhold Hall
Athens, GA 30602-7122
chamih@moe.coe.uga.edu

Hammrich, Penny L. 624
Temple University
337 Ritter Hall
1301 Cecil B. Moore Avenue
Philadelphia, PA 19122
phammric@thunder.ocis.tempLe.edu

Hampton, Virginia R. 553
University of Pennsylvania
Graduate School of Education/PED
3700 Walnut Street
Philadelphia, PA 19104
ghampton@doLphin.upenn.edu

Hanjian, Jini 499
Florida Mental Health Institute
13301 North Bruce B. Downs Boulevard
Tampa, FL 33612

Hanley, Gisella 338
2519 10th Street
Santa Monica, CA 90405
ghanLey@ucLa.edu

Harden, Brenda Jones 242, 276, 289
University of Maryland
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742
bj34@umaiL.umd.edu

Hare, Charles 556, 566
United Community Action Program Head Start
501 North 6th Street
Pawnee, OK 74058

Hargis, Thomas J., Jr.
SWCAC, Inc.
540 5th Avenue
Huntington, WV 25703

Harley, Thelma Lorraine 574
DCPS Head Start Programs
5716 Emerson Street, #B1
Bladensburg, MD 20710

Harms, Thelma O. 552
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
300 Nationsbank Plaza
137 East Franklin Street
Chapel Hill, NC 27514
theLma_harms@unc.edu

Harrell, James A. 15
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447

Harvey, Cathie
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
mhoLmes@nhsa.org

Hatot, Norma J.
HHS-SAMHSA-CMHS
5600 Fishers Lane, Room 15-105
Rockville, MD 20857
nhatot@SAMHSA.gov

Hauser, Stuart T.
Harvard Medical School
Judge Baker Children's Center
3 Blackfan Circle
Boston, MA 02115-5794
shauser@warren.med.harvard.edu

Hawley, Theresa L. 614
Ounce of Prevention Fund
122 South Michigan Avenue, #2050
Chicago, IL 60603

Hayes, Melody 630

Hazzard, Ann 386, 388, 595
Emory University School of Medicine
Pediatrics
Box 26065, Grady Hospital
80 Butler Street
Atlanta, GA 30335
ann_hazzard@oz.ped.emory.edu

Heathfield, Lora Tuesday 503, 537
University of Pennsylvania School of Medicine
Children's Seashore House
3405 Civic Center Boulevard
Philadelphia, PA 19104-4388

Hebbeler, Kathleen 340, 342, 346, 536
SRI International
Health and Social Policy Division
333 Ravenswood Avenue
Menlo Park, CA 94025
KHebb@compuserve.com

Heggins, Martha Jean Adams
South Carolina State University
Head Start
300 College Street, N.E.
Orangeburg, SC 29117

Hegland, Corine
Department of Transportation
2239 New Hampshire Avenue, N.W., Apartment 506
Washington, DC 20037
corine.hegLand@ost.dot.gov

Hegland, Susan M. 162
Iowa State University
Department of Human Development and Family Studies
101 Child Development Building
Ames, IA 50011-1030
shegLand@iastate.edu

Hellman, Esther 532
Creighton University
School of Nursing
2500 California Plaza
Omaha, NE 68178

Hemmeter, Mary Louise 494
University of Kentucky
220 Taylor Education Building
Lexington, KY 40506-0001
mLhemm@opo.uky.edu

Hendricks, Charlotte M. 535, 537
JCCEO Head Start
300 8th Avenue
Birmingham, AL 35204
jhendricks@wwisp.com

Hepburn, Kathy
University of Maryland University College
Head Start Resource and Training Center
University Boulevard at Adelphi Road
College Park, MD 20742
hepbk@hsrtc.umuc.edu

Herer, Gilbert R. 505
Children's National Medical Center
Department of Hearing and Speech
111 Michigan Avenue, N.W.
Washington, DC 20010
gherer@cnmc.org

Herman, Kristine L. 558
328 North Neil Street, Suite B
Champaign, IL 61820
kristyh@infant-parent.com

Hernandez, Donald J. 43
National Academy of Sciences
Board on Children, Youth and Families
2101 Constitution Avenue, N.W.
Washington, DC 20418-3400
donaLd.j.hernandez@ccmaiL.census.gov

Hernandez, Maria G.
California State University at Northridge
624 1/2 North Virgil Avenue
Los Angeles, CA 90004-2318
mgh33471@csun.edu

Hernandez, Susana C.
Maricopa County Head Start
3335 West Durango
Phoenix, AZ 85009

Herran, JoAn Knight 140
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
jherren@acf.dhhs.gov

Herrington, Carolyn D. 525
Florida State University
Learning Systems Institute
4600 UCC
Tallahassee, FL 32306-2540
cherington@Lsi.fsu.edu

Herrmann, Suzannah 605
University of North Carolina at Chapel Hill
School of Education
Campus Box #3500
Chapel Hill, NC 27599-3500
herrmann@unc.edu

Hershfield, Bruce W.
Child Welfare League of America
Child Day Care Services
440 1st Street, N.W.
Third Floor
Washington, DC 20001
bhersh@cwca.org

Hesson-McInnis, Matthew 558
Illinois State University
Department of Psychology
Normal, IL 61790

Hestenes, Linda L. 506
University of North Carolina at Greensboro
Human Development and Family Studies
P.O. Box 26170
Greensboro, NC 27402-6170
LLhesten@erickson.uncg.edu

Hibbard, Shelley 138
Office of Education, Research, and Improvement
555 New Jersey Avenue, N.W.
Room 600
Washington, DC 20208

Hicks, F.Y.
United States Department of Education
OESE/Portals Building
600 Independence Avenue, S.W.
Suite 4400
Washington, DC 20202

Hill, Charles W.
University of New Orleans
5304 Patriots Colony Drive
Williamsburg, VA 23188

Hill, Krista 630

Hill, Suzanne D.
University of New Orleans
5304 Patriots Colony Drive
Williamsburg, VA 23188
suszyh@aoL.com

Hines, Hui 494
University of Kentucky
257 Forest Hill Drive
Lexington, KY 40509
uk06965@ukcc.edu

Hinkle, Donna 488
Office of Education, Research, and Improvement
United States Department of Education
555 New Jersey Avenue, N.W.
Washington, DC 20208
donna_hinkLe@ed.gov

Ho, Joyce 564
University of Denver
Department of Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80210

Hodgson, Cherly 138

Hodson, Ellenor
Riverside County
Office of Education
P.O. Box 868
Riverside, CA 92502

Hoffman, Tom 529
St. Mary's University
San Antonio, TX 78228

Holdsclow, John
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

Holmes, Maggie
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
mhoLme@nhsa.org

Holt, Carol
Yale Child Study Center/Bush Center Head Start
Research Unit
230 South Frontage Road
New Haven, CT 06520

Holt, Judith
Region VI OSQIC
501 Woodlane, #201
Little Rock, AR 72201
hoLtjuditha@exchange.uams.edu

Hong, Gui-Young
MUSC-Department of Psychiatry
850 MUSC Complex-Psych Annex I
Charleston, SC 29425

Hopmann, Marita R. 145
Administration on Children, Youth and Families
Research, Demonstration, and Evaluation Branch
330 C Street, S.W.
Room 2123 Switzer Building
Washington, DC 20447
mhopmann@acf.dhhs.gov

Hopper, Thomas L.
NESD Head Start Program, Inc.
202 South Main Street, Suite 617
Aberdeen, SD 57401

Horm-Wingerd, Diane M. 140, 141
University of Rhode Island
Department of Human Development
209 Transition Center
2 Lower College Road
Kingston, RI 02881-0818
dianehw@uriacc.uri.edu

Horner, Paula L. 540
University of Wisconsin Stevens Point
School of Communicative Disorders
Waupaca, WI 54481
horner@uwsp.edu

Hornstein, John 636
Children's Hospital at Boston
300 Longwood Avenue
Boston, MA 02115
hornstjb@hugse1.harvard.edu

Horowitz, Frances D. 411
City University of New York
Graduate School and University Center
33 West 42nd Street
New York, NY 10036
fdh@aquiLa.gc.cuny.edu

Horowitz, Sandra V. 485
Columbia University
Teachers College
Box 53 - ICCCR
525 West 120 Street
New York, NY 10027
svh5@coLumbia.edu

Horowitz, Sheldon H.
National Center for Learning Disabilities
381 Park Avenue South
Suite 1401
New York, NY 10016
sheLdon@ncLd.org

Hostrum, June
Centers for Disease Control
MS/F-15
Atlanta, GA 30341
wjh0@cdc.gov

Howard, Eboni 172
Northwestern University
School of Education and Social Policy
2115 North Campus Drive
Evanston, IL 60208

Hubbs-Tait, Laura E. 556, 566
Oklahoma State University
Family Relations and Child Development
HES 341
Stillwater, OK 74078
hubbs@okway.okstate.edu

Huberman, Harris 538
ICHAP / MHRA
40 Worth Street, Room 728
New York, NY 10013

Huebner, Colleen Morisset E. 138
University of Washington
Department of Health Services
Box 357230
Seattle, WA 98195-9720
coLLeenh@u.washington.edu

Hughart, Nancy 297, 298
Johns Hopkins School of Public Health
624 North Broadway
Baltimore, MD 21205

Hughes, Margaret Ann 507
California State University at Fullerton
Department of Special Education
Box 6868
Fullerton, CA 92834-6868
mhughes@fuLLerton.edu

Hughey, William
United Planning Organization
Office of Preschool and Day Care
401 M Street, S.W.
Washington, DC 20024

Huston, Aletha C.
University of Texas at Austin
Department of Human Development
115 Gearing
Austin, TX 78712-1097
achuston@maiL.utexas.edu

Hutton, Miles 568
Columbia University
Teachers College
525 West 120th Street
New York, NY 10027
yamyacm@pipeLine.com

Ibrahim, Mona M. 174, 665
Eastern Connecticut State University
104 Sawmill Brook Lane
Mansfield Center, CT 06250-1636
ibrahimm@ecsu.ctstateu.edu

Iglesias, Aquiles 166, 187, 362, 379, 470
Temple University
Department of Communication Sciences
109 Weiss Hall
Philadelphia, PA 19122
igLesias@vm.tempLe.edu

Ingwalson, Brenda
Sheridan Early Childhood Center
4464 Christensen Circle
Littleton, CO 80123
brendaing@aoL.com

Innocenti, Mark S. 597
Utah State University
Early Intervention Research Institute
CPD Annex #1
6580 University Boulevard
Logan, UT 84322-6580
minno@cpd2.usu.edu

Irizarry-Mayoral, Linna
New York University
Maximo Gomez 553
San Juan, PR 00918
cnyuqicd@tLd.net

Irwin, Sharon Hope 512
Specialink
Canadian National Child Care Inclusion Network
P.O. Box 775
Sydney, Nova Scotia
Canada B19 6G9
specLink@atcon.com

Isaacs, Julie
ASPE/DHHS
200 Independence Avenue, S.W.
Washington, DC 20201

Isham, George 260, 266, 272
Health Partners
Chief Medical Officer
P.O. Box 1309
Minneapolis, MN 55440-1309

Isler, Martha 393
United Way
1 Smithfield Street
Pittsburgh, PA 15217
mwi@city-not.com

Ispa, Jean M. 129, 492, 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65211
ispa@showme.missouri.edu

Ivins, Kathleen A. 485
Harvard University Graduate School of Education
Human Development and Psychology
Appian Way
Larsen 708 HUGSE
Cambridge, MA 02138

Iwagaki, Donna 571
University of Southern California
741 West 27th Street
Los Angeles, CA 90007
d.iwagaki@rcf.usc.edu

Jackson, Debra L.
Action for a Better Community, Inc.
Head Start
550 East Main Street
Rochester, NY 14604

Jackson, Sandra C. 256
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
105 Smith Level Road, CB 8180
Chapel Hill, NC 27599-8180

Jacobs, Elaine
Santa Barbara City College
DSPS
1145 Tunnel Road
Santa Barbara, CA 93105

Jacobs, Ellen L. 588
University of Nebraska at Omaha
Kayser Hall, Room 115
Omaha, NE 68182-0054
ejacobs@unomaha.edu

Jacobson, Arminta Lee 618
University of Oregon
P.O. Box 311337
Denton, TX 76203-1337
jacobson@coefs.coe.unt.edu

Jagielo, Linda M. 587
Southwest State University
Early Childhood Education, IL 239
1501 State Street
Marshall, MN 56258-1598
LjagieLo@ssu.southwest.msus.edu

James, Laura
Research Triangle Institute
3040 Cornwallis Road
Research Triangle Park, NC 27709
Ljj@rti.org

Jarrett, Marian H. 386, 387
George Washington University
Newborn Services
2134 G Street, N.W.
Washington, DC 20052
mjarrett@gwu.edu

Jarvis, Carolyn H. 172
New York University
Head Start Q.I.C
726 Broadway, 5th Floor
New York, NY 10003
jarvis@is.nyu.edu

Jefferson-Kerr, Olga M.
Family Development Services, Inc.
3590 North Meridian Street
Indianapolis, IN 46208
ojkerr@fds.org

Jensen, Peter
National Institute of Mental Health
Clinical and Treatment Research
5600 Fishers Lane, Room 18C-17
Rockville, MD 20852

Jessup, Patricia A. 504
University of Michigan
3117 SEB
610 East University
Ann Arbor, MI 48109-1259
pjessup@umich.edu

Jewkes, Abigail 300
Boston Medical Center/BUSM
Department of Psychiatry
1 Boston Medical Center Place
Dowling 300 South
Boston, MA 02118

Johnson, Carlethea 30, 33
Baltimore City Head Start Program
2330 St. Paul Street
Baltimore, MD 21218

Johnson, Christia 615

Johnson, Dana E. 224, 232
University of Minnesota
Box 211 FUMC
420 Delaware Street, S.E.
Minneapolis, MN 55455
johnso008@tc.umn.edu

Johnson, Deborah
University of Rochester
Primary Mental Health Project
685 South Avenue
Rochester, RI 14620-1340

Johnson, Doris McNeeley M. 386, 387
University of the District of Columbia
Washington, DC 20012

Johnson, Gwendolyn 469
Administration for Children and Families
Head Start Bureau, Region IV
Atlanta, GA 30311

Johnson, Kenita
Family Development Services, Inc.
3590 North Meridian Street
Indianapolis, IN 46208
kjohnson@fds.org

Johnson, Lawrence J. 393, 395, 630
University of Cincinnati
College of Education
Office of Research and Development
P.O. Box 210002
432 Teachers College
Cincinnati, OH 45221-0002
Lawrence.johnson@uc.edu

Johnson, Rosalind
NCEMCH
2000 North 15th Street, #701
Arlington, VA 22201
johns598@piLot.msu.edu

Johnson-Powell, Gloria 43, 276, 284
University of Chicago
Chapin Hall Center for Children
1313 East 60th Street
Chicago, IL 60637
johnson-poweLL-gLoria@chmaiL.spc.uchicago.edu

Johnston, Denise 293
Center for Children of Incarcerated Parents
65 South Grand Avenue
Pasadena, CA 91105

Jones, Alison 297
Johns Hopkins School of Public Health
624 North Broadway
Baltimore, MD 21205

Jones, Debra
Columbia University School of Public Health
Center for Population and Family Health
60 Haven Avenue, B-3
New York, NY 10032
fLp1@coLumbia.edu

Jones, Rebecca
National School Board Association
1680 Duke Street
Alexandria, VA 22314

Jones-Dance, Gloria 138
University of Maryland at College Park
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742

Juall, Karen A.
Wheelock College
Professional Studies
200 The Riverway
Boston, MA 02215
nezs52a@prodigy.com

Judge, Sharon 601
University of Tennessee
331 Claxton Addition
Knoxville, TN 37996-3400
shL@utkux.utcc.utk.edu

Jump, Vonda Kay 545
Utah State University
Department of Family and Human Development
Logan, UT 84322-2905
sLLbn@cc.usu.edu

Kagan, Sharon Lynn 190, 198, 204
Yale University
Bush Center in Child Development and Social Policy
310 Prospect Street
New Haven, CT 06511-2188

Kahana-Kalman, Ronit
Albert Einstein College of Medicine
Kennedy Center, Room 220
Bronx, NY 10146
rkkaLmanan@compuserve.com

Kahn, James V.
University of Illinois at Chicago
ECRIP
1640 West Roosevelt Road
M/C 628
Chicago, IL 60608
jkahn@uic.edu

Kalafatich, Maria 138

Kaminski, Ruth 386, 389
University of Oregon
School of Psychology
Eugene, OR 97403

Kanda, Mireille B. 260, 271, 273
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447
mkanda@acf.dhhs.gov

Kane, Elizabeth
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
bethkaneb6@aoL.com

Kaplan, Michael D.
Yale Child Study Center
230 South Frontage Road
New Haven, CT 06520
michaeL.kapLan@yaLe.edu

Kaplan-Sanoff, Margot 296
Boston Medical Center
1 Boston Medical Center Place
MAT 5
Boston, MA 02118

Karp, Naomi 488
National Institute on Early Childhood Development
United States Department of Education
555 New Jersey Avenue, N.W.
Washington, DC 20208
naomi_karp@ed.gov

Karr-Morse, Robin 224, 235
818 N.W. 17th Street, Suite 10
Portland, OR 97209

Karwowski, Marlene
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
mkarwowski@nhsa.org

Kavanaugh, Kate 247
Oregon Social Learning Center
207 East 5th Avenue, Suite 201
Eugene, OR 97401

Keane, Michael J.
The CDM Group, Inc.
5530 Wisconsin Avenue, Suite 1660
Chevy Chase, MD 20815
mkeane@cdmgroup.com

Keating, Kim
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
kkeating@eainet.com

Keefe, Dennis R. 129
Michigan State University
Department of Family and Child Ecology
116 Human Ecology Building
East Lansing, MI 48824
keefed@piLot.msu.edu

Keefe, Nancy 599
Wellesley College
Center for Research on Women
106 Central Street
Wellesley, MA 02181-8259
nkeefe@weLLesLey.edu

Kelley, Michael
Arizona State University
P.O. Box 37100
Phoenix, AZ 85069

Kelly, Kathi M. 527
P.O. Box 4706
Columbia, SC 29240

Kemp, Jayne 467
92 Reservoir Hill Road
Candor, NY 13748

Kennedy, Andrew 319, 325
17315 Studebaker Road
Cerritos, CA 90703

Kennedy, Marti V. 668
Montclair State University
Department of Human Ecology
Valley Road, V-152
Upper Montclair, NJ 07043
kennedym@saturn.montcLair.edu

Kennel, Portia
The Ounce of Prevention Fund
122 South Michigan Avenue, Suite 2050
Chicago, IL 60603

Kermani, Hengameh 496
University of North Carolina at Wilmington
Watson School of Education
106 South College Road
Wilmington, NC 28403
kermanih@uncwiL.edu

Kesner, John E. 539
Georgia State University
Department of Early Childhood Education
University Plaza
Atlanta, GA 30076
ecejek@Langate.gsu.edu

Kessler-Sklar, Susan L. 620
NCJW Center for the Child
53 West 23rd Street, 6th Floor
New York, NY 10010

Killen, Christine
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
ckiLLen@acf.dhhs.gov

King, Frankie
Alabama Council on Human Relations
P.O. Box 409
Auburn, AL 36831

King, Timothy 109, 112, 115, 116, 117
Southeast Community Organization Head Start
10 South Wolfe Street
Baltimore, MD 21231
tking94128@aoL.com

Kisker, Ellen E. 139, 670
Mathematica Policy Research, Inc.
7639 Crestview Drive
Longmont, CO 80501
ekisker@mathematica-mpr.com

Klafehn, Douglas
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447

Klein, Elisa L. 493
University of Maryland
Department of Human Development
3304 Benjamin Building
College Park, MD 20742-1175
ek17@umaiL.umd.edu

Klein, Lisa Greenberg 409
Ewing Marion Kauffman Foundation
Research and Evaluation
4900 Oak Street
Kansas City, MO 64112-2776
LkLein@emkf.org

Knauf, Diana E. 380, 381
Manhattan College
Psychology-CMSV
6301 Riverdale Avenue
Riverdale, NY 10471
dknauf@cmsv.edu

Knitzer, Jane E. 571
National Center for Children in Poverty
Research and Policy Analysis
154 Haven Avenue, 3rd Floor
New York, NY 10032-1180
jk340@coLumbia.edu

Koblinsky, Sally A. 562, 563
University of Maryland at College Park
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742-7515
sk38@umaiL.umd.edu

Kolbusz, Linda M. 172
Community Unit School District #300
Program Development
300 Cleveland Avenue
Carpentersville, IL 60110-1977

Koller, Donna 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65211

Korfmacher, Jon 125, 126, 139
Kempe Prevention Research Center
Department of Pediatrics-UCHSC
1825 Marion Street
Denver, CO 80218
korfmacher.jon@tchden.org

Koroloff, Nancy
Regional Research Institute
1912 S.W. 6th
Portland, OR 97207
koroLon@rri.pdx.edu

Kostelnik, Marjorie J. 129
Michigan State University
Department of Family and Child Ecology
107 Human Ecology Building
East Lansing, MI 48824
kosteLni@piLot.msu.edu

Kraimer-Rickaby, Lisa 623
University of Connecticut
School of Family Studies
348 Mansfield Road, U-58
Storrs, CT 06269-2058
Lkraimer@canr1.cag.unconn.edu

Krauss, Beatrice J. 530
National Development and Research Institute
Institute for AIDS Research
Two World Trade Center
16th Floor
New York, NY 10048
bea.krauss@ndri.org

Kreider, Holly 336, 338
Harvard Family Research Project
Harvard Graduate School of Education
38 Concord Avenue
Cambridge, MA 02138
kreideho@hugse1.harvard.edu

Kresh, Esther
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447
ekresh@acf.dhhs.gov

Krishnakumar, Ambika 255
University of Maryland at Baltimore
Growth and Development Project
700 West Lombard Street
Baltimore, MD 21212
akrisoo1@umaryLand.edu

Kubicek, Lorraine F. 549
University of Colorado Health Sciences Center
Department of Psychiatry/School of Medicine
4200 East 9th Avenue
Campus Box C268-69
Denver, CO 80262
Lorraine.kubicek@uchsc.edu

Kugel, Robert
United States Army
6016 Claiborne Drive
McLean, VA 22101
rkugeL@aoL.com

Kuhns, Carole L.
Georgetown University, School of Medicine
Center for Education in Maternal and Child Health
2000 15th Street, North
Suite 701
Arlington, VA 22201
ckuhns@ut.edu

La Villa, Silvia J.
Kidco Child Care, Inc.
3630 N.E. 1 Court
Miami, FL 33137
kidco@shadow.net

Ladd, Lindsey L. 629
Legislative Office of Education Oversight
77 South High Street
22nd Floor
Columbus, OH 43266-0927
LLadd@Loeo.state.oh.us

Lam, Wendy K.K. 605, 606
University of North Carolina at Chapel Hill
School of Education
108 Peabody Hall
CB #3500
Chapel Hill, NC 27599-3500
wkLam@emaiL.unc.edu

Lamb, Michael E. 139, 205
National Institute of Child and Health Development
National Institute of Health
9190 Rockville Pike
BSA Building, Room 331
Bethesda, MD 20814
Lamb@ssed.nichd.nih.gov

Lamb-Parker, Faith 3, 72, 76, 81, 83, 276, 620
Columbia School of Public Health
Center for Population and Family Health
60 Haven Avenue, B-3
New York, NY 10032
fLp1@coLumbia.edu

Lambert, Richard G. 145, 152, 466, 581
University of North Carolina at Charlotte
Dept. of Ed. Admin., Research, and Technology
3135 Colvard
9201 University City Boulevard
Charlotte, NC 28223-0001
rgLamber@emaiL.uncc.edu

Lamberty, Gontran 251
Maternal and Child Health Bureau
HRSA
5495 Sleeping Dog Lane
Columbia, MD 21045
gLamberty@hrsa.dhhs.gov

Langager, Mark 515
Harvard Graduate School of Education
Larsen Hall, 3F
Appian Way
Cambridge, MA 02138
Langagma@hugse1.harvard.edu

Lange, Garrett W. 596
University of North Carolina at Greensboro
Human Development and Family Studies
P.O. Box 26170
Greensboro, NC 27402
g.wLange@erickson.uncg.edu

Lanzi, K. Robin Gaines 161, 523, 663
University of Alabama
at Birmingham
Civitan International Research
Center
1719 Sixth Avenue South
Birmingham, AL 35294-0021
rLanzi@uab.edu

Lapidus, Carole
JBFCS/ECGT
120 West 57th Street, 11th Floor
New York, NY 10019

Lapidus, Leah Blumberg 568
Columbia University Teachers
College
Clinical Psychology
525 West 120 Street
New York, NY 10027
L.b.Lapidus@CoLumbia.edu

Lawson, Aleta
New River Community Action
Head Start Program
P.O. Box 570
Christiansburg, VA 24073
aLawson@swva.net

Lawson-Holmes, Clara
United States Department
of Education
555 New Jersey Avenue, N.W.
Washington, DC 20706
cLara.Lawson-HoLmes@ed.gov

Lawton, Joseph T. 652, 654
University of Wisconsin
Center for Health Policy and
Program Evaluation
433 West Washington Avenue,
Suite 500
Madison, WI 53703-2703
jtLawton@facstaff.wisc.edu

Layzer, Jean I. 119, 121
ABT Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138
jean_Layzer@abtassoc.com

Leaf, Philip J. 276, 561
Johns Hopkins University
Department of Mental Hygiene
624 North Broadway
Hampton House, Room 819
Baltimore, MD 21205
pLeaf@jhsph.edu

Lee, Mary Alice 533
Children's Health Council
85 Gillett Street
Hartford, CT 06105

Lee, Valerie E. 350, 351, 352, 353, 356, 358, 360
University of Michigan
School of Education, Education
Studies Program
610 East University Avenue
Ann Arbor, MI 48109-1259
veLee@umich.edu

Lee, Yoon-Joo 511
Columbia University,
Teachers College
Center for Infants and Parents
Whittier Hall 924
1230 Amsterdam Avenue
New York, NY 10027
yL211@coLumbia.edu

Lefever, Gretchen
Center for Pediatric Research
3309 Glen Eden Quay
Virginia Beach, VA 23452
gLefever@chkd.com

Leff, Michelle
Johns Hopkins University
2008 Indian Head Road
Ruxton, MD 21204
mLeff@weLchLink.weLch.jhu.edu

Lenzer, Gertrud 411, 414
Society for the Advancement of
Children's Studies
39 Claremont Avenue, #114
New York, NY 10027

Leonard, Carolyn P.
Montgomery County Public Schools
Head Start
4910 Macon Road
Rockinghorse Road Center
Rockville, MD 20852

Lero, Donna S. 512
University of Guelph
Department of Family Studies
Guelph, Ontario
Guelph, Ontario, Canada N1G 1J3
dLero@uogueLph.ca

Letiecq, Bethany L.
University of Maryland
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742
bL38@umaiL.umd.edu

Letteney, Susan G. 530
Families in Transition
Beth Israel Medical Center
295 First Avenue
New York, NY 10003

Levenstein, Phyllis 481
National Center for Parent-Child
Home Program
The Verbal Interaction Project, Inc.
585 Plandome Road, Suite 105B
Manhasset, NY 11030

Levenstein, Susan 481
Via de Tempio, IA
Rome, Italy 00186

Levine, Eliot 338
Harvard Family Research Project
38 Concord Avenue
Cambridge, MA 02138

Levitzky, Susan
American Academy of Pediatrics
161 Madison Avenue
New York, NY 10016

Lewin, Shulamit
EMSC National Resource Center
8737 Colesville Road
Suite 950
Silver Spring, MD 20910
sLewin@emscnrc.com

Lewis, Arlene
Pueblo of Laguna Head Start
Policy Council Chairperson
P.O. Box 798
Laguna, NM 87026

Leyva, Collette 598
Texas A&M University
Department of Educational
Psychology
College of Education
College Station, TX 77843-4225

Liebow, Harriet 126
Catholic University of America
Department of Education
620 Michigan Avenue, N.E.
O'Boyle Hall, Room 239
Washington, DC 20064
Liebow@cua.edu

Lignell, Brett
University of Michigan
Society for Research in
Child Development
505 East Huron, Suite 301
Ann Arbor, MI 48104-1522

Lilly, Terese
United States Department
of Education
Office of Special Education
330 C Street, S.W.
Switzer Building
Washington, DC 20202

Linehan, Ann
Administration on Children, Youth
and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447

Lobach, Katherine 538
NYC Health and Hospital's
Corporation
125 Worth Street, Room 342
New York, NY 10013

Lockhart, Amy
Department of Health and
Human Services
1826 Kilbourne Place, N.W.
Washington, DC 20010
akicjgar@os.dhhs.gov

Lombardi, Joan
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, S.W.
#320F
Washington, DC 20201

Long, Edgarita 471
University of Arkansas
Speech and Hearing Clinic
410 Arkansas Avenue
Fayetteville, AR 72701
edLong@comp.uark.edu

Lopez, Michael L. 119, 163, 359
Administration on Children, Youth
and Families
Research, Development, and
Evaluation Branch
330 C Street, S.W.
Room 2119
Washington, DC 20447
miLopez@acf.dhhs.gov

Lopez, Nelda E. 516
University of Texas at Austin
Department of Curriculum and
Instruction
Sanchez Building 428A
D5700
Austin, TX 78712
h.romo@maiL.utexas.edu

Love, John M. 139
Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
jLove@mathematica-mpr.com

Lovelace, John D.
Southern Illinois University
at Edwardsville
Head Start
411 East Broadway
East Saint Louis, IL 62201
jLoveLa@siue.edu

Low, Sabina 514
Children's Hospital and
Medical Center
4800 Sand Point Way, N.E.
P.O. Box 5371
Seattle, WA 98105-9907

Lowman, Dianne Koontz
Virginia Commonwealth University
Department of O.T.
P.O. Box 980008
Richmond, VA 23298
dLowman@hsc.vcu.edu

Loyde, Judith W.
Regina Coeli Child Development
Center
Head Start
832 East Boston Street, Unit #10
Covington, LA 70433

Lubeck, Sally 504, 608, 631
University of Michigan
School of Education
610 East University, Room 4218
Ann Arbor, MI 48109-1259
sLubeck@umich.edu

Lucariello, Joan M.
American Psychological Association
750 First Street, N.W.
Washington, DC 20002
jLucarieLLo@apa.org

Lucas, Kimber 618
Texas Woman's University
Child Development Center
Denton, TX 76204

Luckey, Evelyn F. 172
Otterbein College
Project REACH
398 South Grant Avenue, #205
Columbus, OH 43215

Lusko, Jeffrey J. 576
Orchards Children's Services
30215 Southfield Road
Southfield, MI 48076
Lusko@fLn.Lib.mi.us

Lynch, Kathleen Bodisch 486
Virginia Commonwealth University
Virginia Institute for Developmental
Disabilities
P.O. Box 843020
Richmond, VA 23284-3020
kLynch@saturn.vcu.edu

Lyon, G. Reid 30, 41, 42
National Institute of Health
National Institute of Child and
Health Development
Building 6100, Room 4B05
9000 Rockville Pike
Bethesda, MD 20892-7510
rL60a@nih.gov

Maahs, Jennifer
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
jmaahs@eainet.com

Macapinlac, Joanna
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

Maccoby, Eleanor E. 21, 22
Stanford University
Department of Psychology, 2130
Stanford, CA 94305-2130
mccoby@psych.stanford.edu

Machida, Sandra K. 498, 647
California State University
Department of Psychology
Child Development Program 220
Chico, CA 95929-0234
smachida@oavax.csuchico.edu

MacPhee, David L. 380, 382
Colorado State University
Human Development and
Family Studies
Fort Collins, CO 80521
macphee@cahs.coLostate.edu

Madden, Mary 581

Madrigal, Anna 529
The University of Texas Health
Science Center
Department of Pediatrics
7703 Floyd Curl Drive
San Antonio, TX 78284-7818

Malabonga, Valerie Ann A. 475, 659
Center for Applied Linguistics
1118 22nd Street, N.W.
Washington, DC 20037
vaLerie@caL.org

Malloy, Zelma M.
A.H.R. Inc. Head Start
1 South New York, Suite 313
Atlantic City, NJ 08401

Malone, June G.
Action for Bridgeport Community Development, Inc.
1070 Park Avenue
Bridgeport, CT 06604
maLone.june@snet.net

Manlove, Elizabeth E.
Penn State University
Human Development and Family Studies
S110 Henderson Building
University Park, PA 16802
eem103@psu.edu

Mann, Emily 326, 327
University of Wisconsin at Madison
1350 University Avenue
Madison, WI 53706
eamann@students.wisc.edu

Mann, Tammy
Zero To Three
734 15th Street, N.W.
Suite 1000
Washington, DC 20005
t.mann@zerotothree.org

Manter, Marcia A.
Community Development Institute
6616 Raytown Road
Kansas City, MO 64133
mmanter@aoL.com

Mantzicopoulos, Panayota Y. 489, 628
Purdue University
Department of Educational Studies
1446 Liberal Arts and Education Building
West Lafayette, IN 47907-1446
mantzi@purdue.edu

Manz, Patricia H. 553
Children's Seashore House
Department of Pediatric Psychology
3405 Civic Center Boulevard
Philadelphia, PA 19104

Maples, Kelly 630

Marcon, Rebecca A. 616
University of North Florida
Department of Psychology
822 Tournament Road
Ponte Vedra Beach, FL 32082
rmarcon@unf.edu

Marickovich, Patricia P.
University of Maryland University College
Head Start Resource and Training Center
2946 Weatherly Court
Blacksburg, VA 24060
marickovic@aoL.com

Markel, Howard 43, 51, 177, 178, 181, 182, 183, 184, 185, 186, 188
University of Michigan
Historical Center for the Health Sciences
2703 Medical Science Building 2
1301 Catherine Street
Ann Arbor, MI 48109-0613
howard@umich.edu

Marshall, Halina M.
University of Rochester
Primary Mental Health Project
685 South Avenue
Rochester, NY 14620-1340
marshaLL@psych.rochester.edu

Marshall, Linda J. 652, 654
University of Wisconsin Medical School
433 West Washington Avenue, Suite 500
Madison, WI 53703
marshaLL@facstaff.wisc.edu

Marshall, Nancy L. 599
Wellesley College
Center for Research on Women
Wellesley, MA 02181
nmarshaLL@weLLesLey.edu

Martin, Pamela P. 665
Michigan State University
Department of Psychology
135 Snyder Hall
East Lansing, MI 48824-1117
martinp3@piLot.msu.edu

Martin, Susanne
Memorial Community Center
1607 Mansfield Street
Cincinnati, OH 45210

Martinez, Ivelisse M. 477
Albion College
Department of Psychology
P.O. Box 515
Chelsea, MI 48118
Imunoz@umich.edu

Martinez, Silvia
American Speech-Language-Hearing Association
Multicultural Education Program Division
10801 Rockville Pike
Rockville, MD 20852
smartinez@asha.org

Marx, Mary 395
University of Cincinnati
Arlitt Center
P.O. Box 210105
Cincinnati, OH 45221-0105
mary.marx@uc.edu

Massey, Marilyn S. 537
Texas Tech University
Department of HPER
Box 43011
Lubbock, TX 79409-3011
massey@ttu.edu

Mathers, Brian 666

Matheson, Catherine 508
UCLA
Los Angeles, CA 90024-1759

Mathews, Michelle 492, 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65211
hdfsmm@showme.missouri.edu

Mayer, Ellen 338
Harvard Family Research Project
38 Concord Avenue
Cambridge, MA 02138

McAllister, Carol L. 132, 139, 336, 337, 338, 343
University of Pittsburgh
Graduate School of Public Health
230 Parran Hall
Pittsburgh, PA 15261
aLLister@pitt.edu

McBride, Brent A. 220, 222
University of Illinois
Human Development and Family Studies
206 Child Development Laboratory Building
1105 West Nevada Street
Urbana, IL 61801
brentmcb@uiuc.edu

McBride, Susan L. 127, 139, 340, 341
Iowa State University
Human Development and Family Studies
101 Child Development Building
Ames, IA 50011
mcbride@iastate.edu

McCabe, Lisa A. 467, 482
Cornell University
Human Development and Family Studies
MVR Hall
Ithaca, NY 14853
Lam4@corneLL.edu

McCarty, Frances 152, 466, 581
Georgia State University
Adult Literacy Center
University Plaza, Suite 367
COE Building
Atlanta, GA 30303
aLcfam@Langate.gsu.edu

McCauley, Linda A. 579
Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Mail Code L606
Portland, OR 97201
mccauLey@phsu.edu

McCullough, Judith 615
University of Denver
Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80208
jmccuLLo@du.edu

McCullough, Patricia A. 544
The University of Toledo
Ed. Psychology, Research and Social Foundation
1614 Sylvania
Toledo, OH 43612
pmccuLL@pop3utoLedo.edu

McDonald, Lynn 274
University of Wisconsin at Madison
FAST Research Project with American Indians
1025 West Johnson Street
Madison, WI 53706
mrmcdona@facstaff.wisc.edu

McDonald, Sarah
HHS/ASPE
1214 33rd Street, N.W.
Washington, DC 20007

McDowell, Ella
National Association of WIC Directors
2001 South Street, N.W.
Suite 580
Washington, DC 20009
nawdLegis@aoL.com

McFadden-Garden, Terri 386, 388
Emory University School of Medicine
Department of Pediatrics
69 Butler Street, S.E.
Atlanta, GA 30303
tmcfadd@emory.edu

McGee, Zina T. 575
2028 Cunningham Drive, #202
Hampton, VA 23666
facmcge@cs.hamptonu.edu

McGrady, Michael
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
mmcgrady@nhsa.org

McGuire, Ron
John XXIII Head Start Center
1393 East Broad Street, 2nd Floor
Columbus, OH 43205
mcguire@bcoL.net

McKee, Patricia
United States Department of Education
OESE/CEP
600 Independence Avenue, S.W.
Portals Building, Suite 4400
Washington, DC 20202
Patricia_McKee@ed.gov

McKenna, Margaret 137
Context Social Cultural Research
9823 44th Avenue, S.W.
Seattle, WA 98136
mmckenna@u.washington.edu

McKey, Ruth Hubbell 153
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
rhmckey@eainet.com

McLaughlin, Joan E. 119, 122
ABT Associates, Inc.
4800 Montgomery Lane
Suite 600
Bethesda, MD 20814
joan_mcLaughLin@abtassoc.com

McLearn, Kathryn T. 296, 442, 444, 456
The Commonwealth Fund
One East 75th Street
New York, NY 10021
ktm@cmwf.org

McMahon, Patricia
Pelavin Research Center
1000 Thomas Jefferson Street, N.W.
Suite 400
Washington, DC 20007
pmcmahon@cir-dc.org

McNeal, Meryl S.
Morehouse School of Medicine
Community Health and Preventive Medicine
720 West View Drive, S.W.
Atlanta, GA 30310
mcneaLm@Link.msm.edu

McPherson, Alma
United States Department of Education
330 C Street, S.W.
Room 3094
Washington, DC 20020

McWayne, Christine M.
University of Pennsylvania
4400 Pine Street, 2F
Philadelphia, PA 19104
mcmackin@doLphin.upenn.edu

Meany, Michael 224
Douglas Hospital for Children
6875 La Salle Boulevard
Montreal, Quebec
Canada H4H 1R3

Medina, Ceci 633
Ceritos College
11110 Alondra Boulevard
Norwalk, CA 90650

Medvin, Mandy B. 463
Westminster College
Psychology Department
Box 101
New Wilmington, PA 16172-0001
medvinm@westminster.edu

Meier, John H.
Preschool Services Department
Disabilities Services Division
250 South Lena Road
San Bernardino, CA 92408

Meisels, Samuel J. 85, 100, 102
University of Michigan
School of Education
610 East University, 1110 SEB
Room 3210
Ann Arbor, MI 48109-1259
smeiseLs@umich.edu

Melhado, Trish 388

Mellina, Karin 555
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079

Melmed, Matthew
Zero to Three
734 15th Street, N.W.
Suite 1000
Washington, DC 20005-1013
m.meLmed@zerotothree.org

Mendez, Julia L. 554, 627
University of Pennsylvania
Graduate School of Education
Psychology in Education Division
3700 Walnut Street
Philadelphia, PA 19104-6216
jmendez@doLphin.upenn.edu

Messer, Stephen
Children's National Medical Center
111 Michigan Avenue, N.W.
Washington, DC 20010
smesser@cnmc.org

Meyer, Harriet Horowitz
The Ounce of Prevention Fund
Finance and Administration
122 South Michigan Avenue
Suite #2050
Chicago, IL 60603

Meyers, Adena 133

Michel, Suzanne H. 521
Allegheny University of the
Health Sciences
Department of Pediatrics
3300 Henry Avenue
MCP, Hahnemann SM
Philadelphia, PA 19129
micheLsh@auhs.edu

Midget, Marlene 331
Northern Panhandle Head Start, Inc.
51 16th Street, Fourth Floor
Wheeling, WV 26003
nphs@Lst.net

Miedel, Wendy T. 483, 500
University of Wisconsin
School of Social Work
1350 University Avenue
Madison, WI 53705
wtmiedeL@students.wisc.edu

Miley, Jennifer 538
ICHAP/MHRA
99 Hudson Street, 10th Floor
New York, NY 10013

Milfort, Roline
University of Miami
Department of Psychology
Psychology Annex Building
P.O. Box 249229
Coral Gables, FL 33124-0721
rmiLfort@umiami.ir.miami.edu

Miller, Benjamin
National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
forkLempt@aoL.com

Miller, James
Administration on Children, Youth
and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447

Miller, Pamela B. 485
Harvard University
156 Woburn Street
Medford, MA 02155-3434
pmboston@aoL.com

Miller, Paul A.
Arizona State University West
Sociology and Behavioral Sciences
4701 West Thunderbird Road
Glendale, AZ 85306
icpam@asu.edu

Miller-Heyl, Jan 382
Dare to Be You
215 North Linden Street
Aspen Building, Suite A
Cortez, CO 81321

Mills, Kay 109, 115, 116, 118
1129 Ashland Avenue
Santa Monica, CA 90405
kaymiLLs@Loop.com

Mills-Jones, Johnnie
Jackson State University
6076 Holbrook Drive
Jackson, MS 39206

Minnes, Ann F. 393, 397
Texas Instruments Foundation
P.O. Box 650311
Mail Station 3906
Dallas, TX 75265-0311
a-minnis@ti.com

Minteer, Jan 463
Lawrence County Head Start, Inc.
301 East Long Avenue
New Castle, PA 16101

Miotke, Linda
NESD Head Start Program, Inc.
202 South Main Street, Suite 617
Aberdeen, SD 57401

Mitchell, Douglas
Riverside County
Office of Education
P.O. Box 868
Riverside, CA 92502

Mitchell, Karen
Administration on Children, Youth
and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447

Moallem, Mahnaz 496
University of North Carolina
at Wilmington
601 South College Road
Wilmington, NC 28403
moaLLemm@uncwiL.edu

Mondanipour, Shahnaz
Lycoming-Clinton Head Start
2138 Lincoln Street
Williamsport, PA 17701

Montgomery, Judy K. 593
Chapman University
333 North Glassell Street
Orange, CA 92866
montgome@chapman.edu

Moon, Minjung
8380 Greensboro Drive, #425
McLean, VA 22102
mmoon@ipo.net

Mooney, Carol Garhart
Belknap-Merrimack Head Start
P.O. Box 1016
2 Industrial Park Drive
Concord, NH 03302
rainbow134@juno.com

Moore, Elsie G.J. 592
Arizona State University
P.O. Box 87061
Tempe, AZ 85287-0611

Moore, Frances
Pueblo of Laguna Head Start
P.O. Box 798
Laguna, NM 87026

Moore, Lin 656
Texas Woman's University
College of Education and
Human Ecology
P.O. Box 425769
Early Childhood and
Special Education
Denton, TX 76204-5769
Lmoore@twu.edu

Moore, Rita 30, 34
12459 Glade Drive
Reston, VA 20191

Moorehouse, Martha 140
Administration for Children
and Families
Department of Health and
Human Services
200 Independence Avenue
Washington, DC 20201
mmorehouse@osasoe.dhhs.gov

Moreno, Robert P. 648
University of Illinois
905 South Goodwin Avenue
Urbana, IL 61801
rpmoreno@uiuc.edu

Morgan, George A. 380, 384
Colorado State University
School of Education
231 Education Building
Fort Collins, CO 80523-1588
gmorgan@Lamar.coLostate.edu

Morgan-Sandoz, Beverly 633
LACOE Head Start Grantee
17317 Studebaker Road
Certios, CA 90703

Morrel, Tanya 570
University of Maryland at Baltimore
Child and Adolescent Psychiatry
701 West Pratt Street
Baltimore, MD 21201
tmoran1@umbc2.edu

Morrison, Frederick J. 658
Loyola University of Chicago
Department of Psychology
6525 North Sheridan Road
Chicago, IL 60626
fmorisj@orion.it.wc.edu

Moss, Marc 120
ABT Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168

Mueller, Daniel P. 474
Wilder Research Center
1295 Bandana Boulevard North,
Suite 210
St. Paul, MN 55108
dan@wiLder.org

Mullen, Laura 524
Connecticut Children's Health
Project
999 Asylum Avenue, 2nd Floor
Hartford, CT 06105

Mulvey, Laurie A. 337
University of Pittsburgh
Office of Child Development
1811 Boulevard of the Allies,
2nd Floor
Pittsburgh, PA 15219
muLveyt@pitt.edu

Mulvihill, Beverly 550
University of Alabama
at Birmingham
Civitan International Research
Center
1720 7th Avenue South, Suite 331H
Birmingham, AL 35294-0017
bmuLvhi@civmaiL.circ.uab.edu

Munoz-Milan, Robinson 560, 570
University of Maryland at Baltimore
Center for Infant Study
408 West Lombard Street
Baltimore, MD 21201
rmunoz@umpsy.ab.umd.edu

Murphy, Karen L. 493
University of Maryland
Department of Human
Development
3304 Benjamin Building
College Park, MD 20742
wonder@wam.umd.edu

Murphy, Lynn 140
New England Head Start Teaching
Center
160 Draper Avenue
Warwick, RI 02889

Murphy, Susan B. 468
319 War Memorial Hall
Blacksburg, VA 24061-0313

Musun-Miller, Linda 604
University of Arkansas at Little Rock
College of Art, Humanities, and
Social Sciences
2801 South University
Little Rock, AR 72204
LmmiLLer@vaLr.edu

Nair, Prasanna 543
University of Maryland School
of Medicine
Department of Pediatrics
700 West Lombard Street
Baltimore, MD 21201-1091
nair@umab.umd.edu

Nalle, Maureen A. 386, 391
University of Tennessee
College of Nursing
1200 Volunteer Boulevard
Knoxville, TN 37996-4110
mnaLLe@utk.edu

Napolitano, Marie 579
Oregon Health Sciences University
CROET L606
3181 S.W. Sam Jackson Park Road
Portland, OR 97201

Natera, Lucia X. 571
University of Arizona
Department of Psychology
Tuscon, AZ 85721

Nayyar, Geeta
American College of Preventive
Medicine
1660 L Street, N.W.
Suite 206
Washington, DC 20036-5603
gn@acpm.org

Neas, Katherine Beh
National Easter Seal Society
700 13th Street, N.W.
Suite 200
Washington, DC 20005
katy-neas@nessdc.org

Needlman, Robert 251, 253
Case Western Reserve University
Rainbow Babies and Children's Hospital
11100 Euclid Avenue
Cleveland, OH 44106
rdn2@po.cwru.edu

Neel, John 551
1764 Homestead Avenue, N.E.
Atlanta, GA 30306-3136

Nelson, Charles A. 224, 228
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455
caneLson@yx.cis.umn.edu

Nelson, Karin 630
University of Cincinnati
College of Education
P.O. Box 210002
Cincinnati, OH 45221-0002

Neufeld, Susan J. 461
Claremont Graduate University
House and Ear Institute
123 East Eighth Street
Claremont, CA 91711
susan.neufeLd@cgu.edu

Neuharth-Pritchett, Stacey 489, 628
The University of Georgia
Department of Elementary Education
427 Aderhold Hall
Athens, GA 30602-7122
sneuhart@coe.uga.edu

Nichols, Irene A.
Northeastern University
360 Huntington Avenue
Boston, MA 02115

Nicolopoulou, Ageliki
Lehigh University
Department of Psychology
17 Memorial Drive East
Bethlehem, PA 18015
agn3@Lehigh.edu

Nielsen, Elizabeth
University of New Mexico
Hokona Hall, Room 245
Albuquerque, NM 87131
enieLsen@unm.edu

Noga, Janice E. 630
University of Cincinnati
Arlitt Child and Family Development Center
P.O. Box 210002
Cincinnati, OH 45221
nogaje@emaiL.uc.edu

Nolte, Sheila 524
Connecticut Children's Health Project
999 Asylum Avenue, Suite 200
Hartford, CT 06105

Noone, Megan J. 554
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19146
mnoone@doLphin.upenn.edu

Nunez, Ralph de Costa
Homes for the Homeless
36 Cooper Square, 6th Floor
New York, NY 10003
hn4061@handsnet.org

O'Brien, Eileen Liscik
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
eobrien@acf.dhhs.gov

O'Brien, Maureen A. 636
Touchpoints Project
1295 Boylston Street, #320
Boston, MA 02115
obrien@a1.tch.harvard.edu

O'Brien, Robert W. 153, 155
The CDM Group, Inc.
5530 Wisconsin Avenue
Suite 1600
Chevy Chase, MD 20815
bobrien@cdmgroup.com

O'Campo, Patricia 583
Johns Hopkins University
Department of Maternal and Child Health
624 North Broadway
Baltimore, MD 21205

O'Sullivan, Julia T. 476
Memorial University
Faculty of Education
St. John's, Newfoundland
St. Johns NF, CA A1B 1R4
juLiao@morgan.ucs.mun.ca

Ochoa, Salvador Hector 598
Texas A&M University
Department of Educational Psychology
College of Education
College Station, TX 77843-4225
shochoa@acs.tamu.edu

Oden, Sherri L. 145
High/Scope Educational Research Foundation
Research Division
600 North River Street
Ypsilanti, MI 48198
sherrio@highscope.org

Ohlson, Cheryl A. 667
The George Washington University
Department of Special Education
2134 G Street, N.W.
Washington, DC 20052
cohLson@gwu.edu

Okoloko, Virginia 145
High/Scope Education Foundation
Head Start Quality Research Center
600 North River
Ypsilanti, MI 48198

Olds, David L. 276, 280, 340, 344, 345, 346, 347, 348, 349
University of Colorado Health Sciences Center
Prev. Res. Center for Family and Child Health
1825 Marion Street
Denver, CO 80218
oLds.david@tchden.org

Omar, Mildred A. 129
Michigan State University
College of Nursing
A121 Life Sciences Building
East Lansing, MI 48824
miLLie@piLot.msu.edu

Ophori, Grace A. 668
Montclair State University
Department of Human Ecology
College of Education and Human Service
Valley Road, M-150
Upper Montclair, NJ 07043
ophorig@aLpha.montcLair.edu

Orr, Suezanne 251, 252
Johns Hopkins University
School of Hygiene and
Public Health
624 North Broadway
Baltimore, MD 21205
sorr@jhsph.edu

Ortiz-Gulardo, Sonia 491
Beginning With Children
Foundation, Inc.
900 Third Avenue, Suite 1801
New York, NY 10022

Ostrom, Jennifer 630

Owens, Elizabeth 664
University of Pittsburgh
Clinical Psychology Center
4015 O'Hara Street
Pittsburgh, PA 15260

Paez, Mariela 332
Harvard University
Graduate School of Education
Larsen Hall #322
Appian Way
Cambridge, MA 02138

Page, Timothy F. 612
University of Tennessee at Knoxville
218 Henson Hall
Knoxville, TN 37996
tpage1@utk.edu

Palmer, Laura 555
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079
paLmerLa@shu.edu

Pan, Barbara Alexander 135, 139
Harvard University
Graduate School of Education
302 Larsen Hall
Cambridge, MA 02138
barbara_pan@harvard.edu

Panella, Michael 555
Seton Hall University
400 Orange Avenue
South Orange, NJ 07079

Parker, Steven A. 296
Boston Medical Center
1 Boston Medical Center Place
MAT 5
Boston, MA 02118

Parkhurst, Sheryl
United States Department of
Education
Office of Special Education
330 C Street, S.W.
Switzer Building
Washington, DC 20202

Parrott, Laurel 160
6776 Wood End Court
Galloway, OH 43119

Pascoe, John M. 43, 177, 181, 182, 183, 185, 260, 271, 272
University of Wisconsin
Department of Pediatrics
University Children's Hospital
600 Highland Avenue
H4/442 Clinical Science Center
Madison, WI 53792-4116
pascoe@macc.wisc.edu

Pasnak, Robert 492, 659
George Mason University
Department of Psychology
4400 University Drive
MSN 3F5
Fairfax, VA 22030-4444
rpasnake@wpgate.gmu.edu

Patel, Asha 589
SVMC Family Care Center
2213 Franklin Avenue
Toledo, OH 43620

Patterson, Jacqueline 583
Johns Hopkins University
Department of Maternal and
Child Health
624 North Broadway
Baltimore, MD 21205
jpatterson@jhsph.edu

Patterson, Joan M. 260, 272
University of Minnesota School
of Public Health
Maternal and Child Health
Box 97 Mayo Building
420 Delaware Street, S.E.
Minneapolis, MN 55455
jasu@tc.umn.edu

Pavkov, Thomas
Purdue University at Calumet
Head Start XXI Resource Center
2200 169th Street
Porter Hall
Room E204
Hammond, IN 46327
tpavkov@nwi.caLumet.purdue.edu

Payton, Estella 274
FAST Research Program
1025 West Johnson Street
Madison, WI 53711

Peay, Lenore 620
Fort George Community Enrichment
Center
Head Start Center
1525 St. Nicholas Avenue
New York, NY 10033

Peisner-Feinberg, Ellen S. 140, 142, 145, 152
University of North Carolina
at Chapel Hill
Frank Porter Graham Child
Develpmental Center
CB #8040, Suite 300
Nations Bank Plaza
Chapel Hill, NC 27599
eLLenpf@unc.edu

Pelcyger, Elaine
American Orthopsychiatric
Association
79 Sheryl Crescent
Smithtown, NY 11787

Pelcyger, Gwynne E.
579 S.W. Sara Boulevard
Port Saint Lucie, FL 34953

Pelcyger, Iran
NAESP
79 Sheryl Crescent
Smithtown, NY 11787

Pena, Elizabeth D. 362, 372, 379
University of Texas at Austin
Department of Communication
Sciences and Disorders
Austin, TX 78704
Lizp@maiL.utexas.edu

Perou, Ruth
Centers for Disease Control
NCEH/BDDD
MS/F-15
Atlanta, GA 30341
rzp4@cdc.gov

Perry, Carol
Family Development Services, Inc.
3590 North Meridian Street
Indianapolis, IN 46208

Perry, Judy
A.C.S./Head Start
Planning, Policy, and Analysis
30 Main Street, 10th Floor
Brooklyn, NY 11201

Perry, Marlo A.
University of Pennsylvania
6100 City Avenue, #1005
Philadelphia, PA 19131
marLo@doLphin.upenn.edu

Perry, Ruth S.
National Safety Council
1025 Connecticut Avenue, N.W.
Washington, DC 20036
perryr@nsc.org

Persky, Victoria 531
University of Illinois at Chicago
School of Public Health
2121 West Taylor Street
Chicago, IL 60612

Peryam, Rick
CAA Butte County
1755 Bird Street
Oroville, CA 95966
rperyam@sunset.net

Peters, Jack
Neighborhood House Association
Head Start
5660 Copley Drive
San Diego, CA 92111

Peterson, Carla A. 127, 340, 341, 348
Iowa State University
Human Development and Family Studies
101 Child Development Building
Ames, IA 50011
carLapet@iastate.edu

Petrelli, Sabrina 630

Phillips, Joy C. 516
University of Texas at Austin
Department of Educational Administration
Sanchez Building 428A
Austin, TX 78749
jphiLips@maiL.utexas.edu

Phillips, Marian B. 601
University of Tennessee
Inclusive Early Childhood Education
327 Claxton Addition
Knoxville, TN 37996-3400
marianp@utkux.utcc.utk.edu

Phillips, Martha M. 161, 523, 663
University of Alabama at Birmingham
Civitan International Research Center
1719 Sixth Avenue South, Suite 235
Birmingham, AL 35233
mphiLLip@civmaiL.circ.uab.edu

Phillips, Susan S. 292, 294
Centers for Youth and Families
5905 Forest Place
Little Rock, AR 72207
susan@aristottLe.net

Pianta, Robert C. 651
University of Virginia
Curry School of Education
147 Ruffner Hall
405 Emmet Street
Charlottesville, VA 22903-2495

Pickrel, Susan G. 133
Medical University of South Carolina
Department of Psychiatry
Cannon Park Place
171 Ashley Avenue
Charleston, SC 29425-0742
pickresg@musc.edu

Piedra, Maria Teresa de la 516
University of Texas at Austin
Department of Curriculum and Instruction
Sanchez Building 428A
Austin, TX 78703
maytep@maiL.utexas.edu

Pierce, Luzanne B. 202
National Association of State Directors of Special Education (NASDSE)
1800 Diagonal Road, Suite #320
Alexandria, VA 22314
Luzanne@nasdse.org

Pimm, June B. 602
University of Miami School of Medicine
Mailman Center for Child Development
Early Intervention Program
1601 N.W. 12th Avenue
Miami, FL 33136

Pinkos, Jon A.
Columbia University
Teachers College
200 West 54th Street, #12J
New York, NY 10019

Piotrkowski, Chaya S. 620
Fordham University
Graduate School of Social Service
New York, NY 10023

Pizzo, Peggy Daly
Judge Baker Children's Center
Parents and Young Children Project
3 Blackfan Circle
Boston, MA 02115
pizzoma@harvard.edu

Planos, Ruth
St. Joseph's Medical Center
Children's Evaluation and Rehabilitation Center
29 Clunic Avenue
Hastings on Hudson, NY 10706

Pleasure, Jeanette 521
Allegheny University of the Health Sciences
Department of Pediatrics - Division of Neonatology
3300 Henry Avenue
Philadelphia, PA 19129

Plutro, Michele A.
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447
mpLutro@acf.dhhs.gov

Pollitt, Ernesto 531
University of California
Department of Pediatrics
Davis, CA 95616

Porter, Ronald C. 527
University of South Carolina
1401 Kathwood Drive
porterrc@coLumb63.dhec.state.sc.us

Porter, Toni 190, 191, 192, 193, 195, 196, 198, 200, 201, 202, 203, 204
Bank Street College of Education
Center for Family Support
610 West 112th Street
New York, NY 10025
tporter@Bn1wt.edu

Post, Jackie 631
University of Michigan
School of Education
610 East University, Room 4218
Ann Arbor, MI 48109-1259
jjpost@umich.edu

Powell, C. Gregg
National Head Start Association
Research and Evaluation
1651 Prince Street
Alexandria, VA 22314
cgpoweLL@aoL.com

Powell, Diane 499
University of South Florida
13301 North Bruce B. Downs Boulevard
Tampa, FL 33612
poweLL@fmhi.usf.edu

Powers, Stefanie
Zero to Three
734 15th Street, N.W.
Suite 1000
Washington, DC 20005
s.powers@zerotothree.org

Preston, Camille L.
Public Policy Office
750 1st Street, N.E.
Washington, DC 20002-4242
camiLLe@virginia.edu

Price, Beatrice 571
University of Southern California
741 West 27th Street
Los Angeles, CA 90007
b.price@rcfusc.edu

Price, Cristofer S. 122
ABT Associates, Inc.
4800 Montgomery Lane
Bethesda, MD 20814
cristofer_price@abtassoc.com

Prince, Cornelus C.
Lynchburg Community Action Group
Head Start
400 Buena Vista Street
Lynchburg, VA 24504

Prindle, Traci 630

Quigg, Claudia 636
1314 North Main Street
Decatur, IL 62526
babytaLk@q-com.com

Radcliffe, Jerilynn 537
University of Pennsylvania School of Medicine
Children's Seashore House
3405 Civic Center Boulevard
Philadelphia, PA 19104-4388

Raikes, Abbie 177, 184, 185, 437
Columbia School of Public Health
Center for Population and Family Health
60 Haven Avenue, B-3
New York, NY 10032
fLp1@coLumbia.edu

Raikes, Helen H. 139
SRI Institute
The Gallup Organization
300 South 68th Place
Lincoln, NE 68510
heLen_raikes@gaLLup.com

Ramey, Craig T. 161, 172, 258, 663
University of Alabama at Birmingham
Pediatrics, Maternal & Child Health, and Sociology
1719 Sixth Avenue South, Suite 137
Birmingham, AL 35294-0021

Ramey, Sharon L. 161, 172, 663
University of Alabama at Birmingham
1719 Sixth Avenue South, Suite 137
Birmingham, AL 35294-0021

Ramirez, Bruce 166, 168
1920 Association Drive
Reston, VA 22091

Ramsey, William K.
Centers for Disease Control and Prevention
MS-F15
Atlanta, GA 30341
wkr1@cdc.gov

Randolph, Suzanne M. 562
University of Maryland at College Park
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742-7515
sr22@umaiL.umd.edu

Rane, Thomas R. 222
Washington State University
Department of Human Development
Hulbert Hall 311
P.O. Box 646236
Pullman, WA 99164-6236

Rangarajan, Anu 670

Rathbun, Julie Ann
Spectrum Health/Butterworth
100 Michigan, N.E.
MC-94
Grand Rapids, MI 49503

Rauh, Virginia A.
Columbia University School of Public Health
Center for Population and Family Health
60 Haven Avenue, B-3
New York, NY 10032
var1@coLumbia.edu

Raver, C. Cybele 590
Cornell University
Human Development and Family Studies
G65 MVR Hall
Ithaca, NY 14853
ccr4@corneLL.edu

Rawlings, Joyce D. 330, 386
Alexandria Head Start
418 South Washington Street
Alexandria, VA 22314

Raymond, Kitty
Infant Resource Center
2531 25 Avenue, S.W.
Calgary, Alberta
Canada T3E OKI

Raymond-Bhatt, Jennifer
Infant Resource Center
2531 25 Avenue, S.W.
Calgary, Alberta
Canada T3E OKI

Recchia, Susan L. 511
Teacher's College, Columbia University
525 West 120th Street, Box 223
New York, NY 10027
sLr20@coLumbia.edu

Reece, Lisa 609
University of North Carolina at Greensboro
Human Development and Family Studies
228 Stone Building
Greensboro, NC 27412

Reed, Diana 463
Westminster College
Preschool Lab
New Wilmington, PA 16172-0001

Reese, Sonia 568
Columbia University
Community Impact
204 Earl Hall
2980 Broadway
Mail Code 2010
New York, NY 10027
sk19@coLumbia.edu

Reich, Carol F. 491
Beginning With Children
Foundation, Inc.
900 3rd Avenue, Suite 1801
New York, NY 10022

Reischl, Thomas M. 129, 172, 665, 671
Michigan State University
Department of Psychology
135 Snyder Hall
East Lansing, MI 48824
reischL@piLot.msu.edu

Resnick, Gary 153, 154
Westat, Inc.
Child and Family Studies Group
1650 Research Boulevard
Rockville, MD 20850
resnicg1@westat.com

Reynolds, Arthur J. 483, 500
University of Wisconsin at Madison
School of Social Work
1180 Observatory Drive
Madison, WI 53706
ajreynoL@facstaff.wisc.edu

Rhitz, Townley 328
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

Rhodes, Daryel 633
ABC Child Development
5324 West Beverly Boulevard
Montebello, CA 90640

Ricciuti, Anne E. 120
ABT Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138

Rice, Mike 393, 397
Texas Instruments Foundation
P.O. Box 650311
Mail Station 3906
Dallas, TX 75265
a-minnis@ti.com

Richner, Elizabeth
Lehigh University
Psychology Department
17 Memorial Drive East
Bethlehem, PA 18015

Riddle, Teresa A.
SECO Head Start/Bernard Van Leer
3920 Rokeby Road
Baltimore, MD 21229

Rimm-Kaufman, Sara E. 651
University of Virginia
P.O. Box 9051
Charlottesville, VA 22906
ser4x@virginia.edu

Rincon, Claudia P.
Children's Television Workshop
1633 Broadway
New York, NY 10019
cLaudia.rincon@ctw.org

Rintoul, Betty
Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709
ber@rti.org

Ripple, Carol H.
Yale University
Department of Psychology
P.O. Box 208205
New Haven, CT 06520-8205
caroL.rippLe@yaLe.edu

Ritz, William C. 487
California State University
Science Education Department
1250 Bellflower Boulevard, F05
Room 118
Long Beach, CA 90840-4501
wcritz@csuLb.edu

Roberts, Debra D. 562
University of Maryland at
College Park
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742-7515
dr123@umaiL.umd.edu

Roberts, Joanne 130, 251, 256
New York University
239 Greene Street, 4th Floor
New York, NY 10003

Roberts, Richard N. 508
Utah State University
Early Intervention Research Institute
6580 University Boulevard
Logan, UT 84322-6580
richr@cpd2.usu.edu

Robertson, Dylan
University of Wisconsin
919 East Eagle Heights
Madison, WI 53705
dLrober1@students.wisc.edu

Robeson, Wendy Wagner 599
Wellesley College
Center for Research on Women
106 Central Street
Wellesley, MA 02181
wrobeson@weLLesLey.edu

Robinson, David S. 160
Simmons College
School of Social Work
51 Commonwealth Avenue
Boston, MA 02116
drobinson@simmons.edu

Robinson, JoAnn L. 125
University of Colorado
Health Sciences Center
1825 Marion Street
Denver, CO 80304
Robinson.JoAnn@tchden.org

Robinson, Ruth
Columbia School of Public Health
Center for Population and
Family Health
60 Haven Avenue, B-3
New York, NY 10032
fLp1@coLumbia.edu

Robinson, Stephanie
United States Senate Labor
Committee
SH-527 Hart Building
Washington, DC 20510
stephanie_robinson@Labor.senate.gov

Rodriguez, Alfonso
NHA Head Start
5660 Copley Drive
San Diego, CA 92111

Rodriguez, Carmen G.
Columbia University Head Start
Public Health
601 West 168th Street, #42
New York, NY 10032
CR14@coLumbia.edu

Rodriguez, James L. 513
University of Washington
Box 357925
Seattle, WA 98195

Rogers, Enid
NESD Head Start Program, Inc.
202 South Main Street, Suite 617
Aberdeen, SD 57401

Rogers, Katherine
Columbia School of Public Health
Center for Population and
Family Health
60 Haven Avenue, B-3
New York, NY 10032

Rogers, Lisa H. 637
Child Development Resources
P.O. Box 280
Norge, VA 23127-0280

Roggman, Lori A. 134, 139, 545
Utah State University
Department of Family and
Human Development
UMC 2905
Logan, UT 84322-2905
faLori@cc.usu.edu

Rohrbaugh, Susan 395
4978 Deer Run Place
Westerville, OH 43081-4895

Romer, Maureen 520
Albert Einstein College of Medicine
Rose F. Kennedy Center
1410 Pelham Parkway South
Bronx, NY 10461

Romo, Harriett D. 516
University of Texas at Austin
Department of Curriculum and
Instruction
Sanchez Building 428A
D5700
Austin, TX 78712
h.romo@maiL.utexas.edu

Rookwood, Joyce A.
ACF-Head Start-Region II
26 Federal Plaza, Room 1243
New York, NY 10278
jrookwood@acf.dhhs.gov

Roopnarine, Jaipaul L. 220
Syracuse University
Child and Family Studies
Syracuse, NY 13244-1250

Rosen, Alison
Capital Area Head Start
44 Butler Street
Harrisburg, PA 17055

Rosen, Judith
Office for Children
Head Start Program
12011 Government Center Parkway,
9th Floor
Fairfax, VA 22035

Rosenblatt, Shira 139
1019 Corning Street
Los Angeles, CA 90035-2003
shira@ucLa.edu

Rosoff, Saul R. 109, 114, 319
6544 Sulky Lane
Annandale, VA 22003

Rossman, B.B. Robbie 564
University of Denver
Department of Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80210
rossman@du.edu

Roth, Jeffrey 586
University of Florida/Early
Head Start
Department of Pediatrics
P.O. Box 100296
Gainesville, FL 32610-0296
jeffroth@ufL.edu

Roth, Shirley P. 542
National Children's Center
3400 Martin Luther King Junior
Avenue, S.E.
Washington, DC 20032
roth8608@aoL.com

Rothenberg, E. Dianne 166, 168
ERIC/EECE
51 Gerty Drive
Champaign, IL 61820-7469
rothenbe@uiuc.edu

Rothlein, Joan 579
Oregon Health Sciences University
CROET L606
3181 S.W. Samuel Jackson Park Road
Portland, OR 97201

Roundtree, Wanda 184, 185
Home Instruction Program for
Preschool Youngsters
220 East 23rd Street
New York, NY 10010

Rowe, Meredith 135, 582
Harvard Graduate School
of Education
Human Development and
Psychology
Larsen Hall
Appian Way
Cambridge, MA 02138
roweme@hugse1.harvard.edu

Roy, Mary E.
General Accounting Office
441 G Street, N.W.
Room 5F54
Washington, DC 20548

Royal, Sheila
OCAN/CB/ACYF/ACF
330 C Street, S.W.
Switzer Building, Room 242
Washington, DC 20447
sroyaL@acf.dhhs.gov

Rudin, Barbara J.
Caliber Associates, Inc.
10530 Rosehaven Street, Suite 400
Alexandria, VA 22302
rudinb@caLib.com

Ruiz, Donna 630

Rukstele, Ramona 576
Orchards Children's Services
Sinai Hospital
30215 Southfield Road
Southfield, MI 48076
Lusko@tLn.Lib.mi.us

Rush, Mary Lou 395
Ohio Department of Education
Division of ECE
65 South Front Street, Room 309
Columbus, OH 43266

Sabatino, Christine 126
Catholic University of America
National Catholic School of
Social Service
620 Michigan Avenue, N.E.
Shahan Hall, Room 100
Washington, DC 20064
sabatino@cua.edu

Sadovsky, Adrienne 659
George Mason University
c/o Dr. Robert Pasnak
Psychology Department, MSN 3F5
Fairfax, VA 22030

Saifer, Steffen L.
Portland State University
Early Childhood Training Center
P.O. Box 1491
Portland, OR 97207-1491
steffen@ses.pdx.edu

Salas, Jo Ann 516

Samels, Karen 464
PACER Center
4826 Chicago Avenue South
Minneapolis, MN 55417

Santana, Juanita H. 579
Administration on Children, Youth and Families
Head Start Bureau
800 4th Street, S.W.
N-518
Washington, DC 20024
jsantana@aoL.com

Santos, Janis
Holyoke-Chicopee-Springfield Head Start, Inc.
662 High Street
Holyoke, MA 01040
jsantos@headstart.org

Santos, Rosa Milagros 166, 168
University of Illinois
61 Children's Research Center
51 Gerty Drive
Champaign, IL 61820
rsantos@uiuc.edu

Sarreck-Hindin, Toby J.
Teachers College, Life Program
6 Balmoral Drive
New City, NY 10956-2202
toby@cyburban.com

Sauceda, Mary
Rainbow Community Head Start
1038 West Sedgley Avenue
Philadelphia, PA 19133

Savage, Hallie E. 548
Clarion University
116 Davis Hall
Clarion, PA 16214
hsavage@maiL.cLarion.edu

Sayger, Thomas 274
University of Memphis
Memphis, TN 38105

Scharfstein, Dan 297

Scheer, Linda J.
New York University
Resource Access Project-Region II
726 Broadway, 5th Floor
New York, NY 10003
Ls15@is3.nyu.edu

Schiffman, Rachel F. 129, 139, 671
Michigan State University
College of Nursing
A112 Life Sciences Building
East Lansing, MI 48824
rschiff@piLot.msu.edu

Schuler, Maureen E. 543
University of Maryland at Baltimore
Department of Pediatrics
700 West Lombard Street, 2nd Floor
Baltimore, MD 21201
mschuLer@umaryLand.edu

Schultz, Madelyn C.
Administration on Children, Youth and Families
Head Start Bureau
330 C Street, S.W.
Switzer Building
Washington, DC 20447
mschuLtz@acf.dhhs.gov

Schultz, Margaret D. 603
SUNY at Stony Brook
Department of Psychology
Farmingville, NY 11738
russgrd2@psychL.psy.sunysb.edu

Schultz, Thomas W.
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447

Schuman, Andrea F.
Brandeis University
Heller School
14 Charlemont Street
Newton Highlands, MA 02161
schuman@binah.cc.brandeis.edu

Schutte, Deborah 582
Harvard Graduate School of Education
Human Development and Psychology
Larsen Hall
Appian Way
Cambridge, MA 02138
schuettde@hugse1.harvard.edu

Schwarting, Gene 588
OPS
3215 Cuming Street
Omaha, NE 68131

Schwartz, Barbara E.
New York University-QIC-D
School of Education
726 Broadway, 5th Floor
New York, NY 10003
bs11@is3.nyu.edu

Schwartz, Lisa 590
Columbia University
Department of Psychology
1190 Amsterdam Avenue
New York, NY 10027
schwartz@psych.coLumbia.edu

Schweinhart, Lawrence J. 145, 662
High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, MI 48198-2898
Larrys@highscope.org

Scoville, Sandra
University of Maryland University College
Head Start Resource and Training Center
University Boulevard at Adelphi Road
College Park, MD 20742
scous@hsrtc.umuc.edu

Seefeldt, Carol 158, 386, 600
University of Maryland
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742-1131
cs14@umaiL.umd.edu

Sekino, Yumiko 511
Columbia University, Teachers College
Center for Infants and Parents
525 West 120th Street, Box 98
New York, NY 10027
ys93@coLumbia.edu

Serna, Loretta
University of New Mexico
COE/Special Education Hokona Hall-257
Albuquerque, NM 87131
rett@unm.edu

Severson, Herbert H. 244, 247
Oregon Research Institute
Special Education
1715 Franklin Boulevard
Eugene, OR 97403
herb@ori.org

Sewell, Margaret Garnett 498
University of Arizona
Division of Family Studies
P.O. Box 210033
Tucson, AZ 85721
msewell@u.arizona.edu

Shafer, Connie
University of Maryland University College
Head Start Research and Training Center
R.R. 1 Box 592B
East Freedom, PA 16637
cshafergL@aoL.com

Shannon, Jacqueline 130
New York University
239 Greene Street, 4th Floor
New York, NY 10003

Sharp, Elizabeth 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65211

Shatz, Marilyn 477
University of Michigan
Psychology Department
2038 EE, 525 East University Avenue
Ann Arbor, MI 48109-1109

Shaw, Daniel S. 664
University of Pittsburgh
Department of Psychology
4015 O'Hara Street
604 Old Engineering Hall
Pittsburgh, PA 15260-0001

Shaw, Sarah 515
14 Henry Avenue, #1
Somerville, MA 02144
shawsa@hugse1.harvard.edu

Sheppard, Nancy 260, 269
Higher Horizons Head Start
5920 Summers Lane
Falls Church, VA 22041

Sherlak, G. Carolyn
Administration for Children and Families
601 East 12th, Room 276
Kansas City, MO 64106
csherLak@acf.dhhs.gov

Sherrod, Lonnie R. 205, 350, 352, 354, 356, 358, 442, 455, 457
William T. Grant Foundation
570 Lexington Avenue, 18th Floor
New York, NY 10022
Lrsherrod@worLdnet.att.net

Shiminski, James A. 481
Pittsfield Public Schools
Pittsfield, MA 01201

Shinn, Mark 386, 389
University of Oregon
School of Psychology
Eugene, OR 97403

Shonkoff, Jack P. 15, 16, 224, 239
Brandeis University
Florence Heller Graduate School
P.O. Box 9110
MS 035
Waltham, MA 02254-9110
shonkoff@binah.cc.brandeis.edu

Siantz, Mary Lou de Leon 576
University of Washington School of Nursing
Department of Family and Child Nursing
Box 357262
Seattle, WA 98195-7262
msiantz@u.washington.edu

Sibley, Annette 551
Quality Assist, Inc.
368 Moreland Avenue, N.E.
Suite 240
Atlanta, GA 30307
ansibLey@aoL.com

Siegel, Clare
Friends of the Family
Early Head Start
1001 Eastern Avenue
Baltimore, MD 21202

Siegel, Willa Choper
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447
wsiegeL@acf.dhhs.gov

Sigel, Irving 72, 78, 81
Educational Testing Services
Rosedale Road
Princeton, NJ 08541
isigeL@ets.org

Silver, Judith 521
Allegheny University of the Health Sciences
Department of Pediatrics
3300 Henry Avenue
Philadelphia, PA 19129

Silverman, Fran 530
Families in Transition
Beth Israel Medical Center
295 First Avenue
New York, NY 10003

Simmons, Mary
Tennessee State University
330 10th Avenue North
Box 141
Nashville, TN 37203

Simms, Earline M.
South Carolina State University
Head Start
300 College Street, N.E.
Campus Box 7067
Orangeburg, SC 29117
esimms@scsu.edu

Simoneau, Aurilla
Child Advocates of Blair County
319 Sycamore Street
Altoona, PA 16602

Simpson, Jean
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447
jsimpson@acf.dhhs.gov

Simpson, Maureen 630

Sims, Belinda E. 561
Johns Hopkins University
Department of Mental Hygiene
624 North Broadway
Room 806
Baltimore, MD 21205
bsims@jhsph.edu

Sinclair, Esther 576
UCLA Neuropsychiatric Hospital
Psychiatry Department
300 Medical Plaza
Room 1253
Los Angeles, CA 90095
esincLair@mednet.ucLa.edu

Singh, Kusum 468
Virginia Tech
315 East Eggleston
Blacksburg, VA 24061-0302
ksingh@vt.edu

Siuta, Shari L.
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
ssiuta@eainet.com

Slaughter-Defoe, Diana T. 172
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104
dianasd@gse.upenn.edu

Smith, Camille
Centers for Disease Control
NCEH/BDDD
4770 Buford Highway, N.E.
Atlanta, GA 30341

Smith, Connie Jo 534
Western Kentucky University
Training and Technical Assistance Service
344 Tate Page Hall
Bowling Green, KY 42101
connie.smith@wku.edu

Smith, Karen
Census Bureau
Population Division
FB#3, Room 2353
Washington, DC 20233
ksmith@census.gov

Smith, Nancy McK. 126
Catholic University of America
Department of Education
O'Boyle Hall, Room 235
Washington, DC 20064
smith@cua.edu

Smith, Sheila A. 119
New York University
School of Education
239 Greene Street, Fourth Floor
New York, NY 10003
sheiLa.smith@nyu.edu

Smith, Shelley L. 607
Children's Television Workshop
One Lincoln Plaza
New York, NY 10023
sheLLey.smith@ctw.org

Smith, Stephanie W.
AESOP Enterprises, Ltd.
236 Massachusettes Avenue, N.E.
#400
Washington, DC 20002
gnssmith@eroLs.com

Smollar, Jacqueline 140
1843 Ralston Place
Crofton, MD 21114
jsmoLL@aoL.com

Snow, Catherine E. 135, 332
Harvard University
Graduate School of Education
Larsen Hall Room 313
Cambridge, MA 02138
snowcat@hugse1.harvard.edu

Sobel, Andrea J. 574
The George Washington University
Teacher Preparation and Special Education
2134 G Street, N.W.
Washington, DC 20052
asobeL@gwis2.circ.gwu.edu

Solano-Forero, Oscar 531
University of Illinois at Chicago
2035 West Taylor Street
Chicago, IL 60612

Solchany, Joanne 137, 138
University of Washington
6411 65th Avenue, N.E.
Seattle, WA 98115
jsoLchan@u.washington.edu

Solomon, Judith 533
Children's Health Council
85 Gillett Street
Hartford, CT 06105

Son-Yarbrough, Whasoup 497
2559 Lovett Lane
Graham, NC 27253

Spar, Karen
Congressional Research Service
101 Independence Avenue, S.W.
Washington, DC 20540-7440

Spargo, Elizabeth L. 463
Lawrence County Head Start, Inc.
301 East Long Avenue
New Castle, PA 16101

Spatig, Linda 160, 321
Marshall University
Educational Foundations
400 Hal Greer Boulevard
Huntington, WV 25755
spatig@marshaLL.edu

Spears, Nancy 109, 111, 117
Alabama Council on Human Relations
P.O. Box 409
Auburn, AL 36831-0409

Speer, Paul W.
CSCD/Rutgers University
School of Social Work
100 Joyce Kilmer Avenue
Building 4161, Room 214
Piscataway, NJ 08854
pspeer@rci.rutgers.edu

Speirer, Janet L.
Community Development Institute
Region VIII HSQIC
9745 East Hampden Avenue, Suite 310
Denver, CO 80231

Spellmann, Mark 130
New York University School of Social Work
Research Department
One Washington Square North
New York, NY 10003
mes4@is2.nyu.edu

Spence, Helen 561
Umoja Head Start
1500 Harlem Avenue
Baltimore, MD 21217

Speth, Timothy
Northwest Regional Educational Laboratory
101 S.W. Main Street, Suite 500
Portland, OR 97204
spetht@nwreL.org

Spicer, Paul 126, 139
University of Colorado Health Sciences Center
Psychiatry Department
4455 East 12th Avenue
A011-13
Denver, CO 80220
pauL.spicer@uchsc.edu

Spieker, Susan J. 137
University of Washington
Center for Human Development and Disability
Box 357920
Seattle, WA 98195-7920
spieker@u.washington.edu

Squibb, Betsy
University of Maine at Farmington
Franklin Hall
Farmington, ME 04938
squibb@maine.maine.edu

St. Pierre, Robert G. 119, 121
ABT Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138
bob_stpierre@abtassoc.com

Stabile, Isabel
Florida State University
1339 East Lafayette
Tallahassee, FL 32301

Stanford, Beverly Hardcastle 640
Azusa Pacific University
Graduate Education
901 East Alosta Avenue
Azusa, CA 91702-7000
stanford@apu.edu

Starost, Huei-Juang 556
Oklahoma State University
FRCD
116 West 37th Street
Stillwater, OK 74074

Steel, Molly Anne Miller 566
Oklahoma State University
FRCD
Stillwater, OK 74078

Stell, Regina Patton
Riverside County
Office of Education
P.O. Box 868
Riverside, CA 92502

Stewart, LaVern 561
Union Baptist Head Start
1211 Druid Hill Avenue
Baltimore, MD 21217

Stiller, Bruce 247
200 North Monroe
Eugene, OR 97402

Stolzberg, Judith E. 481
Pittsfield Public Schools
Pittsfield, MA 01201

Stoneman, Zolinda
University of Georgia
University Affiliated Program
RC-850 College Station Road
Family Sciences Center II
Athens, GA 30602-4806
zo@arches.uga.edu

Stormshak, Beth 386, 389
University of Oregon
Counseling Psychology
Eugene, OR 97403

Stott, Frances 614
Erikson Institute
420 North Wabash Street
Chicago, IL 60610

Stowitschek, Joseph J. 136, 513
University of Washington
College of Education
4725 30th Avenue, N.E.
Seattle, WA 98105-4021
stowi@u.washington.edu

Straceski, Joanne 635
Teachers College, New York City
4025 Chestnut Street
Philadelphia, PA 19104

Strauss, Rachelle M. 660
University of California at Irvine
P.O. Box 4705
Irvine, CA 92616
rstrauss@uci.edu

Stremmel, Andrew J. 468
Virginia Tech
317 Wallace Hall
Blacksburg, VA 24061-0416
astremme@vt.edu

Strickland, Bonnie
Maternal and Child Health Bureau
5600 Fishers Lane, Parklawn 18-A-18
Rockville, MD 20857
bstrickLand@hrsa.dhhs.gov

Strobino, Donna 297, 298
Johns Hopkins School of Public Health
Department of Maternal and Child Health
624 North Broadway
Baltimore, MD 21205

Strobridge, Michele A. 140, 144
Washington County Head Start
18 River Street
Hudson Falls, NY 12839

Struck, Myra
AID for Education
8204 Fenton Street
Silver Spring, MD 20910

Stuart, Michele T. 637
Child Development Resources
P.O. Box 280
Norge, VA 23127
speciaLcare@gc.net

Stubbs-Gillette, Shirley 409
KCMC Child Development Corporation
2104 East 18th Street
Kansas City, MO 64127
giLLette@qnL.com

Sullivan, Laurie 550
Civitan International Research Center
Department of Psychology
1719 6th Avenue South
Birmingham, AL 35294-0021

Sulzby, Elizabeth 362, 376, 379
University of Michigan
School of Education
610 East University Avenue
Ann Arbor, MI 48109-1259

Sumansky, John 442, 448, 457
Toshiba America Foundation
126 East 56th Street, 28th Floor
New York, NY 10022

Summers, Jean Ann 128, 139, 336, 339
University of Kansas
Juniper Gardens Children's Project
650 Minnesota
Kansas City, KS 66101
jsummers@kuhub.cc.ukans.edu

Swanson, Dena Phillips 607
University of Pennsylvania
CHANGES
3700 Walnut Street, GSE
Philadelphia, PA 19104
denas@gse.upenn.edu

Swanson, Mark E. 138
University of Arkansas
University Affiliated Program
501 Woodlane, Suite 210
Little Rock, AR 72205
swansonmerke@exchange.uams.edu

Swearingen, Laure 664
University of Pittsburgh
Department of Psychology in Education
5C01 Forbes Quad
Pittsburgh, PA 15260-7478

Sweeney, Ray
CD Publications
5204 Fenton Street
Silver Spring, MD 20906

Swift, Jean
Pal-Tech, Inc.
1901 North Fort Myer Drive, #301
Arlington, VA 22209
jswift@paL-tech.com

Sykes, Dennis J. 395
Ohio State University
Center for Special Needs Population
700 Ackerman Road, Suite 440
Columbus, OH 43202
sykes.3@osu.edu

Szanton, Eleanor S.
Johns Hopkins School of Public Health
3707 Ingomar Street, N.W.
Washington, DC 20015

Takanishi, Ruby 442
Foundation for Child Development
345 East 46th Street
New York, NY 10017
ffcd-ruby@worLdnet.att.net

Talley, Susan 590
The University of Toledo
Educational Psych., Research, and Social Found.
Toledo, OH 43606
staLLey@uoft02.utoLedo.edu

Tamis-LeMonda, Catherine 130, 139
New York University
Department of Applied Psychology
239 Greene Street, #537
New York, NY 10003
cst@xp.psych.nyu.edu

Tannen, Rebekah 520
Albert Einstein College of Medicine
Rose F. Kennedy Center
1410 Pelham Parkway South
Bronx, NY 10461

Tarullo, Louisa B. 139, 153, 163, 164
Administration on Children, Youth and Families
Research, Demonstration and Evaluation Branch
330 C Street, S.W.
#2130
Washington, DC 20447
LbtaruLLo@acf.dhhs.gov

Tatem, David 630
University of Cincinnati
College of Education
P.O. Box 210002
Cincinnati, OH 45221-0002

Taylor, Angela R. 498
University of Arizona
Division of Family Studies
P.O. Box 210033
210 FCR Building
Tucson, AZ 85721
artayLor@u.arizona.edu

Taylor, Elizabeth R. 529
University of Texas
Department of Pediatrics
Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284
tayLorer@uthscsa.edu

Taylor, Helen H. 4, 103
Adminstration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20013

Taylor, Karen B. 157, 650
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
105 Smith Level Road
Campus Box 8180
Chapel Hill, NC 27599-8180
Karen_TayLor@unc.edu

Taylor, Matthew J. 597
Utah State University
Early Intervention Research Institute
6580 University Boulevard
Logan, UT 84322-6580
mtayLor@cpd2.usu.edu

Taylor, Nancy E. 126
Catholic University of America
Department of Education
Washington, DC 20003
tayLor@cua.edu

Teibloom-Mishkin, Judy 547
Chicago Health Connections
3411 West Diversy
Chicago, IL 60647

Telleen, Sharon L. 531
University of Illinois at Chicago
School of Public Health
2035 West Taylor Street
Chicago, IL 60612
teLLeen@uic.edu

Temple, Judy 483
Northern Illinois University
Department of Economics
910 Parkview Drive
Stoughton, WI 53589
jtempLe@niu.edu

Teti, Laureen O. 517
University of Maryland at Baltimore City
Department of Psychology
Baltimore, MD 21228

Thiel de Bocanegra, Heike 43, 54, 177, 179, 180, 183, 186
New York University School of Medicine
New York Task Force on Immigrant Health
Division of Primary Care
550 First Avenue
New York, NY 10016
ht8@is.nyu.edu

Thompson, Ray H. 160
University of South Dakota
INTEC, School of Education
414 East Clark Street
Vermillion, SD 57069-2307
rthompso@charLie.usd.edu

Thornburg, Kathy R. 129, 139, 492, 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65211
krt@showme.missouri.edu

Thorne, Judy M.
Research Triangle Institute
Center for Research in Education
3040 Cornwallis Road
Research Triangle Park, NC 27709
thorne@rti.org

Tighe, Erin A. 554
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104
etighe@doLphin.upenn.edu

Timberlake, Elizabeth M. 126
The Catholic University of America
National Catholic School of Social Service
Shahan Hall, Room 125
Cardinal Station
Washington, DC 20064
timberLake@cua.edu

Tippins, Prudence
University of Washington
4301 Prestwould Court
Fredericksburg, VA 22408
prudencet@msn.com

Tomasky, Tracy
Head Start
1331 Camphor Lane
Davis, CA 95616
ttomasky@sanjuan.edu

Tonniges, Tom 260, 263, 271
American Academy of Pediatrics
Community Pediatrics
141 North West Point Boulevard
Elk Grove Village, IL 60007

Torrey, Carol C. 495
Southeastern Louisiana University
P.O. Box 879
Hammond, LA 70402
ctorrey@seLu.edu

Tout, Kathryn
Child Trends, Inc.
4301 Connecticut Avenue, N.W.
Suite 100
Washington, DC 20008
ktout@chiLdtrends.org

Townley, Kim F. 494
University of Kentucky
Family Studies
305 Funhouser Building
Lexington, KY 40506-0054
fam006@ukcc.uky.edu

Townley, Nora 538
ICHAP / MHRA
40 Worth Street, Room 728
New York, NY 10013

Travers-Gustafason, Dianne 532
Creighton University
School of Nursing
2500 California Plaza
Omaha, NE 68178

Troutman, Rebekah V.
Dothan City Schools
Head Start
500 Dusy Street
Dothan, AL 36301
rut@aoL.com

Turben, Susan H. 633
Turben Developmental Services Foundation
2550 SOM Center Road
Suite 120
Willoughby Hills, OH 44094
susan@turben.com

Turchi, Janet 140, 142
North Carolina Head Start Learning Center
800 Eastowne Drive, Suite 105
Chapel Hill, NC 27514

Turner, Colleen
University of Pennsylvania
2606 South Street, #2
Philadelphia, PA 19146
cturner@doLphin.upenn.edu

Turner, Jean
Yale University
Department of Psychology
P.O. Box 208205
New Haven, CT 06520-8205
jdturner@minerva.cis.yaLe.edu

Twining-Martin, Jacquelyn A.
United States Department of Education
Office of Special Education
330 C Street, S.W.
Switzer Building
Washington, DC 20202

Tyler, Rachelle M. 190, 200
Regents of UCLA
Department of Pediatrics
300 UCLA Medical Plaza
Room #3300
Los Angeles, CA 90095-7033
rtyLer@pediatrics.medsch.ucLa.edu

Uhlmann, Ruth M.
3902 Jocelyn Street, N.W.
Washington, DC 20015

Unruh, Sarah 325
United States Department of Education
555 New Jersey Avenue, N.W.
Room 604
Washington, DC 20208
sarah_unruh@ed.gov

Vaccaro, Tara 641
Syracuse University
202 Slocum Hall
Syracuse, NY 13244-1250

Valle, Maria P. 555
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079
mariavaLLe@aoL.com

Van, Saundra
CEDA of Cook County, Inc.
National Head Start Association
208 South LaSalle Street
Chicago, IL 60604

Van Buren, Amy 630

Van Dusen, Catherine
Office of Management and Budget
725 17th Street, N.W.
Room 8222
Washington, DC 20503

Vandell, Deborah L. 57, 61, 69, 71, 409
University of Wisconsin
Department of Educational Psychology
1025 West Johnson Street
Madison, WI 53706-1706
dvandeLL@macc.wisc.edu

Vartuli, Sue 577
University of Missouri at Kansas City
R241 School of Education
615 East 52nd Street
Kansas City, MO 64110
svartuLi@cctr.umkc.edu

Vaughan, Peggy 338, 610
P.O. Box 38-1523
Cambridge, MA 02138-1523
vaughape@hugse1.harvard.edu

Veieweg, Karen 571
University of Southern California
741 West 27th Street
Los Angeles, CA 90007
KVieweg@rcf.usc.edu

Velazquez, Nilsa M.
Kidco Child Care, Inc.
3630 N.E. 1 Court
Miami, FL 33137
kidco@shadow.net

Vivas, Victoria M.
Alexandria Head Start
8600 Venoy Court
Alexandria, VA 22309

Vizzard, Lila Herndon
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
CB #8180
105 Smith Level Road
Chapel Hill, NC 27599
LiLa_vizzard@unc.edu

Vlasin, Rebecca
Iowa State University
101 Child Development Building
Ames, IA 50011
rvLasin@iastate.edu

Vogler, James D. 633
Los Angeles County Office of Education
9300 Imperial Highway, Room 210
Downey, CA 90242
vogLerJames@Lacoe.edu

Von Blum, Ruth 487
California State University, Long Beach
3605 Ashwood Avenue
Los Angeles, CA 90066
rvbconsuLt@mediaone.net

Vondra, Joan I. 664
University of Pittsburgh
School of Education
5C01 Forbes Quadrangle
Pittsburgh, PA 15260-7478
vondra@fs1.sched.pitt.edu

Waddell, Bernadette
Cheyney University
P.O. Box 354
Cheyney, PA 19319

Wadhwa, Perminder 518
Broward County Health Department
Dental Section
2412-A S.W. 6th Avenue
Ft. Lauderdale, FL 33315
pwadhwa@doh.state.fL.us

Wald, Penelope J. 386, 387
George Washington University
Teacher Preparation and Special Education
2134 G Street, N.W.
Washington, DC 20052

Walden, Beth
Utah State University
Region VIII DSQIC
6582 Old Main Hill
Logan, UT 84322-6582

Walka, Helen 531
Sonoma State University
California Institute Human Services
1801 East Cotati
Rohnert Park, CA 94928-3609
heLen.waLka@sonoma.edu

Walker, Hill M. 244, 247
Institute on Violence and Destructive Behavior
1265 University of Oregon
Eugene, OR 97403-1265
hiLL_waLker@ccmaiL.uoregon.edu

Walker, Jerry P. 629
Ohio General Assembly
Legislative Office of Education Oversight
77 South High Street, 22nd Floor
Columbus, OH 43266-0927
jwaLker@Loeo.state.oh.us

Walker, Mary Ann 166
Region IX QIC-DS
CIHS/Sonoma State University
5189 Verdugo Way
Camarillo, CA 93012
mawaLker@vcss.k12.ca.us

Walker, Yvonne R.
Fort Valley State University
Head Start
P.O. Box 4395
1005 State University Drive
Fort Valley, GA 31030

Wall, Barbara
Tennessee State University
330 10th Avenue North
Box 141
Nashville, TN 37203

Wall, Shavaun 126, 139
Catholic University of America
Department of Education
620 Michigan Avenue, N.E.
Washington, DC 20064
waLLs@cua.edu

Wallace, Barbara 622
Teachers College, Columbia University
525 West 120th Street, Box 114
New York, NY 10027

Wallace, Ina F.
Research Triangle Institute
Center for Research in Education
P.O. Box 12194
Research Triangle Park, NC 27709-2194
waLLace@rti.org

Walton, Judy R. 644
Howard University
Department of BLEC
School of Business
2600 6th Street, N.W.
Washington, DC 20020
jwaLton@bschooL.howard.edu

Walzer, Sarah E. 481
National Center for Parents-Child Home Program
The Verbal Interaction Project, Inc.
585 Plandome Road
Manhasset, NY 11030

Wang, Aimin 649
Miami University
Department of Education Psychology
118 McGuffy Hall
Oxford, OH 45056
wanga@muohio.edu

Waseta, Teresa
Pueblo of Laguna Head Start
Policy Council Chairperson
P.O. Box 798
Laguna, NM 87026

Washington-Thomas, Lisa
Administration for Children and Families
370 L'Enfant Promenade, S.W.
5th Floor
Washington, DC 20447
LWashington@acf.dhhs.gov

Wasik, Barbara H. 605, 606
University of North Carolina at Chapel Hill
School of Education
CB 3500
Chapel Hill, NC 27599-3500

Wasserman, John D.
Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079
john_wasserman@hmco.com

Watt, Norman F. 478, 599
University of Denver
Department of Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80210
nwatt@du.edu

Waxler, Trellis L.
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447

Weatherl, Rutha 666
Lincoln Action Program
1145 High Street
Lincoln, NE 68502
rweatherL@juno.com

Weaver, Laurie R. 598
University of Houston at Clear Lake
2700 Bay Area Boulevard, Box 348
Houston, TX 77078-1098

Webb, Mary Bruce 157, 276
Administration on Children, Youth and Families
330 C Street, S.W.
Room 2411
Washington, DC 20447
mbwebb@acf.dhhs.gov

Weisner, Thomas 508
UCLA
Los Angeles, CA 90024-1759

Weiss, Andrea 537
2227 Delancey Street, Apartment 2R
Philadelphia, PA 19103

Weiss, Heather B. 338
Harvard Graduate School of Education
Harvard Family Research Project
38 Concord Avenue
Cambridge, MA 02138

Welcher, Doris 561
Union Baptist-Harvey Johnson Head Start Center
1211 Druid Hill Avenue
Baltimore, MD 21217

Wellenkamp, Jane C. 338
University of California at Los Angeles
Graduate School of Education
1029C Moore Hall
Mailbox 95-1521
Los Angeles, CA 90095-1521
jweLLenk@ucLa.edu

Werner, Melissa 645
University of Alabama at Birmingham
School of Education
Curriculum and Instruction
Birmingham, AL 35294
mwerner@beLLsouth.net

West, Jennifer C. 564
University of Denver
Department of Psychology
Frontier Hall
2155 South Race Street
Denver, CO 80208
jwest@nova.psy.du.edu

Westby, Carol E. 362, 366
Wichita State University
Department of Communication Disorders
Alburque, NM 87106
mocha@unm.edu

Wetherby, Amy M. 85, 88, 101
Florida State University
Department of Communication Disorders
RRC-107
Tallahassee, FL 32306-2007
awetherb@garnet.acns.fsu.edu

Whetung, Valorie
Health Canada
Childhood and Youth Division
Tunney's Pature
Jeanne Mance Building, A.L. 1909C2
Ottawa, Ontario
Canada K1A 1B4

White, Ann Marie 599
Wellesley College
Center for Research on Women
106 Central Street
Wellesley, MA 02181
awhite@weLLesLey.edu

White, Sheldon H. 399, 404, 405
Harvard University
Department of Psychology
33 Kirkland Street
William James Hall 1130
Cambridge, MA 02138-2044
shw@wjh.harvard.edu

White-Tennant, Gambi
New York University
Head Start Q.I.C.
726 Broadway, 5th Floor
New York, NY 10003

Whitehurst, Grover "Russ" J. 30, 35, 655
SUNY at Stony Brook
Psychology Department
1 Young's Lane
Setauket, NY 11733
gwhitehurst@ccmaiL.sunysb.edu

Whiteside-Mansell, Leanne 138
University of Arkansas at Little Rock
CRTL, WACR
2801 South University Avenue
Little Rock, AR 72204
Lwhiteside@uaLr.edu

Whitfield, Horace 274
FAST Replication in Head Start
Baltimore, MD

Whitney, Laura 633
Ceritos College
11110 Alondra Boulevard
Ceritos, CA 90650

Wiener, Louise W.
Learning and Leadership in Families
501 School Street, S.W.
Suite 600
Washington, DC 20024

Wilcox, Cynthia 560
University of Maryland at Baltimore
Child and Adolescent Psychiatry
701 West Pratt Street
Baltimore, MD 21201
cwiLcox@umpsy.ab.umd.edu

Wilder, Nick 630
University of Cincinnati
College of Education
P.O. Box 210002
Cincinnati, OH 45221-0002

Williams, Bonnie
Head Start
52 North Calver Street
Baltimore, MD 21229

Williams, Jo Ann
Child Development, Inc.
Arkansas Head Start Association
P.O. Box 2110
Russellville, AR 72811
cdiinc@cswnet.com

Williams, Myrna B.
2004 Claxton Drive
Winston-Salem, NC 27127

Williamson, Gordon 85, 92, 100, 101
John F. Kennedy Medical Center
Pediatric Rehabilitation Department
2050 Oak Tree Road
Edison, NJ 08820
gwiLLiamson@jfk.hbocvan.com

Willis, Sarah
United States Department of Education
Office of Special Education
330 C Street, S.W.
Switzer Building
Washington, DC 20202

Wilson, Janet H. 468
New River Community Action Head Start
125 Arrowhead Trail
P.O. Box 2549
Christiansburg, VA 24073

Wilson, Stacia
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
swiLson@eainet.com

Wilson, Stephan M. 494
University of Kentucky
107 Erikson Hall
Lexington, KY 40506-0050
swiLson@pop.uky.edu

Winn, Laura
University of Georgia
University Affiliated Programs
River's Crossing
Athens, GA 30605
Lwinn@uga.cc.uga.edu

Wise, Janet M.
City of Phoenix Head Start
Human Services/Education Division
200 West Washington
19th Floor
Phoenix, AZ 85003
jwise@ci.phoenix.az.us

Withers, Barbara B.
Action for a Better Community, Inc.
530 East Main Street
Rochester, NY 14604

Wolf, Anne 332, 334
Harvard University
Graduate School of Education
14 Appian Way
Cambridge, MA 02138
woLfan1@hugse1.harvard.edu

Wolfe, Randi B. 578
Northern Illinois University
Department of Curriculum and Instruction
162-L Gabel Hall
Dekalb, IL 60115-2854
rwoLfe@niu.edu

Wolfe, Thomas M.
Utah State University
Early Intervention Research Institute
Logan, UT 84322
sL5y2@cc.usu.edu

Wolfenstein, Miriam 617
University of Missouri
Human Development and Family Studies
31 Stanley Hall
Columbia, MO 65201
C603606@showme.missouri.edu

Wolverton, E. Dollie 315, 319, 320, 321, 322, 325, 326, 330, 331
Administration on Children, Youth and Families
Head Start Bureau
P.O. Box 1182
Washington, DC 20447

Wood, Karren 386
The George Washington University
2134 G Street, N.W.
Washington, DC 20052
kiwood@gwu.edu

Woodard, Dixie R.
University of Guam
P.O. Box 5179
UOG Station
Mangilao, GU 96923
dixiew@uog9.uog.edu

Wortham, Archie 516
University of Texas at Austin
Department of Curriculum and Instruction
Sanchez Building 428A
Austin, TX 78712
archie@fLash.net

Wright, Cathy
Ellsworth Associates, Inc.
1749 Old Meadow Road
Suite 600
McLean, VA 22102-4398
cwright@eainet.com

Yazejian, Noreen M. 142
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
Nations Bank Plaza, Suite 300
CB 8040
Chapel Hill, NC 27599-8040

Yazzie, Ernie R.
Navajo National Head Start
Box 370
Windor Rock, AZ 86515

Yellow Robe, Caroline 109, 110, 115, 117
Indian Head Start
P.O. Box 699
Harlem, MT 59526

Yellowitz, Michele L. 296
The Commonwealth Fund
1 East 75th Street
New York, NY 10021

York, Martha 671
Region II Community Action Agency
1214 Greenwood Avenue
Jackson, MI 49203
region2caa2@dmci.net

Yoshikawa, Hirokazu 571
New York University
6 Washington Place
New York, NY 10003
hiro@psych.nyu.edu

Younoszai, Tina M. 158, 591, 600
University of Maryland
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742-1131
tinay@wam.umd.edu

Yusem, Anita W.
United Cerebral Palsy Association
Box 332
Gwynedd Valley, PA 19437
ayusem@aoL.com

Zale, Kathleen
National School Boards Association
1680 Duke Street
Alexandria, VA 22314

Zeece, Pauline Davey 649
University of Nebraska at Lincoln
104F RLH
Lincoln, NE 68583-0801
hdev003@unLvm.unL.edu

Zeisel, Susan 256
University of North Carolina at Chapel Hill
Frank Porter Graham Child Development Center
105 Smith Level Road
CB 8180
Chapel Hill, NC 27599-8180

Zigler, Edward F. 9, 103, 109, 113, 116, 117, 118, 315, 318, 321, 325, 327, 328, 329, 331, 399, 400, 404, 405, 407, 408
Yale University
Department of Psychology
P.O. Box 208205
2 Hillhouse Avenue
New Haven, CT 06520-8205
mariLyn.barry@yaLe.edu

Zill, Nicholas 153, 154
Westat, Inc.
Child and Family Studies Group
1650 Research Boulevard
TA2126
Rockville, MD 20850-3129
ziLLn1@westat.com

Zimiles, Herbert 592
Arizona State University
P.O. Box 87061
Tempe, AZ 85287-0611

Zorn, Debbie 630
University of Cincinnati
College of Education
P.O. Box 210002
Cincinnati, OH 45221-0002

Zuckerman, Barry 296, 300
Boston Medical Complex
Department of Psychiatry
1 Boston Medical Center Place
Dowling - 300 South
Boston, MA 02118

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

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